Risk Adjustment and Reinsurance Preliminary Workplan for the State of Illinois

Prepared by Wakely Consulting Group - Mary Hegemann, FSA, MAAA and Syed Mehmud, ASA, MAAA with contributions from Ross Winkelman, FSA, MAAA, James Woolman, Julie Peper, FSA, MAAA, and Patrick Holland

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1 Overview

Wakely was retained by Health Management Associates (HMA) as a subcontractor on a contract with the Illinois Department of Insurance (DOI) to complete analysis to support planning activities related to the creation and operation of health benefit Exchanges under the Affordable Care Act (ACA). This report presents the scope of work related to the 3Rs: risk adjustment, reinsurance, and risk corridors. The following components are discussed in this report:

Deliverable 1: Wakely has undertaken a thorough review of the Notice for Public Rule-Making (NPRM) and the final rules issued by HHS in March 2012 which discuss the 3Rs, with a focus on providing guidance to the State of Illinois (State) based on the state's specific characteristics and recent decisions related to the ACA. This report provides extensive coverage of the NPRM and final rules throughout the body of the report.

Deliverable 2: To further assist the State, Wakely developed a recommended timeline through 2015 to prepare for the implementation of an Exchange, including data required for carriers to price 2014 and 2015 policies. This timeline will assist in outlining key decisions that need to be made, major activities and milestones, and specific responsibilities for the state as well as carriers.

While the scope of this project was generally limited to the reinsurance program by the State, guidance on the risk adjustment program has also been provided.

Deliverable 3: Recommendations on governance and structure for reinsurance have been provided in the body of the report, particularly in section 7. Given the wide variety of options related to potential "owners" of various portions of the reinsurance process, additional input will be required from the State to more specifically address the most advantageous way to approach governance and structure of this program. Wakely recommends that Illinois have the federal government administer reinsurance for the 2014 benefit plan year, but also recommends for the State to consider administering the program in 2015 and 2016.

Deliverable 4: Finally, since the State does not contemplate the completion of the All Payers Claims Database (APCD) prior to 2014, Wakely has provided a high-level review of key considerations in developing APCDs and high-level comparisons to other states in section 6.2. These may be useful for the State in the event that the APCD is developed for use in post-1/1/2014 analyses required for these two programs and other programs such as risk corridors. A great amount of effort is necessary for the creation of an APCD; however, we believe it would be possible for Illinois to produce an APCD in time for it to be useful for 2015 analyses.

Wakely has made every attempt to directly address the key decisions to be made in light of the State's commercial market, existing infrastructure, and current tendencies toward various courses of action such as stakeholder involvement. However, in some instances there is a range of options dependent on decisions by the State, which have also been highlighted.

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2 Executive Summary

On July 11, 2011, the U.S. Department of Health and Human Services (HHS) issued proposed rules, titled "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment." In March 2012, HHS issued final rules on this subject. The rules discuss standards for these programs for states and health insurance issuers (e.g. health insurance companies and HMOs). The rules related to reinsurance and risk adjustment generally allow states additional flexibility in return for increased state responsibility.

2.1 General Timeline

Our standard recommendation for states is that they begin as early as possible in order to address state-specific organizational, legislative, or process issues. While we have developed several specific timelines within the main body of this document, Table 1 contains the recommended timeline associated with the following scenario and considerations, specific to Illinois, related to tasks for plan years 2014 and 2015:

- Illinois will not administer a "state alternative" for risk adjustment or reinsurance effective for the 2014 plan year.
- Illinois carriers have contracted with Wakely Consulting Group to calculate the average risk scores for the small group and non-group markets. Participants in the study represent 86% of the Illinois small group market and 96% of the Illinois non-group market. Therefore, the State does not need to conduct risk adjustment simulations prior to 2014 to assist carriers with the pricing of their products.
- This timeline also assumes that Illinois will consider administering a state alternative risk adjustment mechanism and the temporary reinsurance program beginning for the 2015 plan year.

Even though Illinois will elect to have HHS administer risk adjustment in 2014, the State should strongly consider supplying carriers with enough overall market information to enable them to establish reasonable premium rates for 2015 products, as it is highly unlikely that HHS will be able to provide such information in time for rates to be filed with the State. In steps 14 and 15 of Table 1, we have assumed that the State or carriers will collectively address this issue.

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Table 1: Timeline Overview for Reinsurance and Risk Adjustment (Preparation and Implementation for 2014 and 2015 Benefit Years) Assumes State Begins Administering Both Programs in 2015			
	Key Steps	**Task Owner**	**Timing**
1	Federal risk adjustment model and reinsurance parameters for 2014 released	Federal	Oct-12
2	Stakeholder buy-in, project plan, data request for simulation	Carriers*	Current-Jan 2013
3	Data collection for simulation	Carriers*	Jan-13
4	Analyze and provide results for simulation	Carriers*	Jan -Feb 2013
5	Communicate the 2014 Notice of Benefit and Payment Parameters	Federal or State	Mar-13
6	Carriers submit 2014 rate filings and products to State	Carriers	Jun-13
7	State to decide whether to proceed with alternative model and/or parameters in 2015	State	Jun -Sep 2013
8	States must inform HHS of intent to collect reinsurance contributions for 2015 benefit year	State	Sep-13
9	2014 products and premiums are publicly available; enrollment begins	Federal or State	Oct-13
10	Federal risk adjustment model and reinsurance parameters for 2015 released	Federal	Oct-13
11	States can submit an alternative model and reinsurance parameters for 2015	State	Nov-13
12	HHS to provide decision on 2015 submitted alternative models and parameters	Federal	Jan-14
13	Carriers begin submitting reinsurance assessments to HHS; continues throughout year	Carriers/Federal	Jan - Dec 2014
14	Collect disease prevalence reports from carriers (simulation that helps with 2015 pricing)	State or Carriers*	Jan-14
15	Provide overall disease prevalence reports and risk scores for 2013 by market (simulation for 2015 pricing)	State or Carriers*	Feb - Mar 2014
16	HHS collects 2014 reinsurance claims from carriers and calculates reimbursement throughout year	Carriers/Federal	Feb - Dec 2014
17	Communicate the 2015 Notice of Benefit and Payment Parameters	State	Mar-14
18	Carriers to submit rate filings for 2015 products	Carriers	Jun-14
19	Collect 2014 initial risk adjustment data and calculate interim risk score	State or Carriers*	Nov - Dec 2014
20	Carriers submit 2015 reinsurance assessments to the State throughout year	Carriers/State	Jan - Dec 2015
21	State collects 2015 reinsurance claims from carriers and calculates reimbursement throughout year	Carriers/State	Feb - Dec 2015
22	Monitor 2015 reinsurance fund balance (assessments less reimbursements)	State	Quarterly in '15
23	Collect final 2014 risk adjustment data and calculate final risk score	Federal	Mar - Apr 2015
24	Bill and collect final 2014 risk adjustment payments, then make payments to carriers	Federal	May - Jun 2015
25	Proposed due date for initial 2014 MLR filings	Carriers/State	Jun-15
26	Carriers to submit 2014 data on risk corridor program	Carriers	Jul - Aug 2015
27	Audit 2014 risk adjustment results and communicate with carriers	Federal	Jul - Dec 2015
28	HHS to bill and collect 2014 interim risk corridor payments and make payments to others	Federal	Sep - Oct 2015
29	Collect initial 2015 risk adjustment data and calculate interim risk score	State	Sep - Oct 2015
30	Bill and collect interim 2015 risk adjustment payments, then make payments to carriers	State	Nov - Dec 2015
31	Set IBNR for reinsurance program in 2015	State	Dec 15 - Jan 16
32	Collect final risk adjustment data and calculate final risk score for 2015	State	Mar - Apr 2016
33	Bill and collect final risk adjustment payments for 2015, then make payments to carriers	State	May - Jun 2016
34	Proposed due date for 2015 MLR filings	Carriers/State	Jun-16
35	Carriers to submit 2015 data on risk corridor program to HHS	Carriers	Jul - Aug 2016
36	Audit 2015 risk adjustment results and communicate with carriers	State	Jul - Dec 2016
37	HHS to bill and collect interim 2015 risk corridor payments and make payments to others	Federal	Sep - Oct 2016

Carriers*: This designation represents the carriers working collaboratively to find an outside source that will collect data from multiple carriers. For example, Wakely Consulting Group recently went under contract with carriers representing 86% of the Illinois small group market and 96% of the Illinois individual market in order to produce a simulation of risk adjustment results. More information about this analysis can be found at www.wakelysimulation.com.

This outline is covered in more detail later in the report.

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2.2 Key Decisions

Provided in the table below are key decisions for the State to make with regard to risk adjustment and reinsurance leading up to implementation of the ACA in 2014.

	Table 2: Key Decisions
	Initial Planning Period: Now through June 2013
1	Will the small group and individual markets be merged?
2	Will the definition of small groups be expanded to 99 lives prior to 2017?
3	Will the State implement a Basic Health Plan (BHP)?
4	Will Illinois expand Medicaid eligibility?
5	What, if any, legislative action is required?
	Making Decisions Regarding Risk Adjustment and Reinsurance Administration (for 2015 Plan Year) : Jun – Sep 2013
6	Should State consider alternative methodologies/parameters?
7	What is the level and method of interaction with carriers?
8	What alternative risk adjustment methodologies should be explored?
9	What alternative reinsurance parameters should be considered?
10	Will State administer risk adjustment?
11	Will State administer reinsurance?
12	Determine whether State will file “alternative methodologies or parameters”
13	Will detailed claims (centralized) or high-level summaries (distributed) be received?
14	What are the data elements required from carriers?
	Providing Assistance to Carriers: Jan - Dec 2014
15	With carriers, decide on timing and type of information to be provided (for 2015 rates)

Engaging carriers in the decision-making process particularly around possible administration of risk adjustment and reinsurance for plan year 2015 and also for determining the timing and type of information they will want in 2014 in order to price their 2015 products will be an important function of the State. To expedite communications, Appendix A has been provided as material that could be used internally at the State and also could be supplied to stakeholders in an initial kickoff meeting. Appendix A is a condensed outline of key immediate timing considerations and decisions for the State.

2.3 Analyses for 2014 and 2015 Pricing

One primary focus of this report is to identify key analyses that should be completed in order for carriers to offer reasonable premium rates for 2014 and 2015 products. If carriers do not receive credible information specific to their plan, there are concerns that 2014 premium rates could include excessive conservatism. While ACA requirements such as minimum loss ratio

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(MLR) and risk corridor thresholds, as well as general competition in the market, are expected to have mitigating effects on high levels of conservatism, a certain degree of conservatism will still exist going into 2014. The timeline provided with this report contemplates analyses, referred to as "simulations," to be performed in 2013 and 2014 with the intention of helping carriers reduce unnecessary conservatism in their 2014 and 2015 premium rates.

Our timeline assumes that rate filings will need to be completed within six months of the Exchange initiation (or by 7/1/2013 for 1/1/2014 policies), which in turn means key information needs to be available to carriers by April 2013 for the filing of 2014 products, and by April 2014 for the filing of 2015 products. This should be reviewed for reasonableness by Illinois.

For reinsurance, upon release of the federal parameters in October 2012, existing carriers will be able to analyze their own claims experience to determine the possible recoveries expected in the 2014 plan year. Carriers will need to take into account the following key parameters, which are described in more detail in Section 6.4 of the report.

- Attachment point
- Maximum coverage level
- Coinsurance level

However, carriers will also need to consider if the reinsurance mechanism will collect enough in assessments in order to pay the reinsurance recoveries according to the federal reinsurance parameters. Illinois can assist carriers by accumulating information that would help inform carriers of the expected overall reinsurance assessments to be collected, compared to the expected recoveries for the overall Illinois individual market. Considering the limited time between now and April 2013 and the fact that Illinois does not have an APCD, we recommend that the State focus on assisting carriers for the pricing of 2015 products in this regard.

We believe Illinois should allow HHS to administer risk adjustment and reinsurance for plan year 2014 because of the limited time available to submit alternative methodologies and to secure a reinsurance administrator. However, the state should consider alternative parameters for plan year 2015, allowing more control over the State's allocation of the assessment to cover claim reimbursements, and allowing Illinois to more appropriately reflect any market-specific trends or factors. The State would also be allowed to increase the assessment, if needed, to allow for covering the administrative costs of the reinsurance program and to further minimize the rate shock to the individual market in 2015 and later. If Illinois decides to administer the reinsurance program and therefore collect reinsurance contributions for the 2015 benefit year, the State must inform HHS by September 2013 of this intention. Alternative methodologies and reinsurance parameters need to be filed with HHS by the November in the calendar year

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two years prior to the plan year of implementation. In other words, if Illinois decides to submit an alternative risk adjustment model or alternative reinsurance parameters for the 2015 plan year, the State must submit the alternatives to HHS by November 2013.

Based on the final rules published by HHS, the following points are important to keep in mind with regard to the reinsurance program:

- HHS will collect reinsurance assessments from self-funded (ERISA) plans for the amount of the HHS-determined assessment rate plus administrative expenses Illinois has determined to be appropriate.
- HHS is willing to collect the comparable amounts of reinsurance assessments for fully insured plans as well.
- If Illinois wants to increase reinsurance collections inclusive of administrative costs beyond what is established by HHS, Illinois would need to administer the collection of assessments for fully insured plans. In this scenario, HHS would continue to collect the HHS-determined assessment amounts plus the administrative expenses from self-funded plans. The increased assessments would only be applicable to fully insured plans.
- If Illinois chooses alternative parameters, which are used to determine reinsurance payments to issuers, then Illinois would need to administer the payments to issuers.

Even though Illinois has decided to allow HHS to manage the risk adjustment program, pricing actuaries will still require the following three key pieces of information for 2014 and 2015 premium setting:

- Average risk score of their current enrolled population versus the market average
- Average risk score of the currently uninsured population that will become insured in 2014 and 2015, especially as it relates to the non-group market
- Average cost of a currently uninsured individual who is expected to join the insurance market relative to the individuals currently insured

Illinois carriers have contracted with Wakely Consulting Group to calculate the average risk scores for the small group and non-group markets. Participants in the study represent 86% of the Illinois small group market and 96% of the Illinois non-group market. Therefore, the State does not need to conduct risk adjustment simulations prior to 2014 to assist carriers with the pricing of their products. General information regarding this simulation is available at www.wakelysimulation.com.

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However, we recommend that Illinois work with carriers to determine the timing and type of information needed in early 2014 in order to price their 2015 products. As shown in Table 1, we recommend collecting information on disease prevalence in early 2014.

The following table outlines the key steps related to the reinsurance program through 2015, assuming Illinois will allow HHS to administer the program for the 2014 plan year but assumes Illinois will consider administering the reinsurance program for the 2015 plan year. A more specific timeline is provided in Appendix B. Appendix C provides a timeline overview for risk adjustment and reinsurance.

Table 3: Reinsurance Main Steps

Timing	Main Steps
Oct-12	Release of federal parameters
Now - Nov 12	Communicate with carriers and supply data request
Jun-13	Carriers submit 2014 rate filings and products to State, including adjustment for reinsurance assessments and recoveries
Jun -Sep 2013	State to decide whether to proceed with alternative model and/or parameters in 2015
Sep-13	States must inform HHS of intent to collect reinsurance contributions for 2015 benefit year
Nov-13	Submit alternative parameters to HHS effective in 2015, if applicable
Jan-14	HHS to provide decision on 2015 submitted alternative models and parameters
Jan - Dec 2014	Carriers begin submitting reinsurance assessments to HHS; continues throughout year
Feb - Dec 2014	HHS collects 2014 reinsurance claims from carriers and calculates reimbursement throughout year
Mar-14	Communicate the 2015 Notice of Benefit and Payment Parameters
Jun-14	Carriers to submit rate filings for 2015 products
Jan - Dec 2015	Carriers submit 2015 reinsurance assessments to the State throughout year
Feb - Dec 2015	State collects 2015 reinsurance claims from carriers and calculates reimbursement throughout year
Quarterly in '15	Monitor 2015 reinsurance fund balance (assessments less reimbursements)
Dec 15 - Jan 16	Set IBNR for reinsurance program in 2015

While only reinsurance has been presented above as this is Illinois' focus, the risk adjustment timeline would look very similar. In addition to the two programs noted above, other ACA developments that the state will need to consider in the upcoming months are as follows:

- Risk Corridor – As a federally managed program, the State should direct the carriers to look to HHS for direction or any new information
- MLR guidelines – Similarly, the carriers will need to understand the ins and outs of the program in order to factor into their 2014 pricing
- State Exchange – As it relates to the state Exchange, carriers will expect Illinois to provide more information on what this market will look like. Key factors include:

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- Expansion of small group definition to 50-100 for the Exchange
- Whether small group and individual markets will merge
- Whether a Basic Health Plan will be initiated in the State (i.e. how active a purchaser the State will be in the market)
- Uniformity of regulation in and outside of the Exchange

2.4 Stakeholder Engagement Plan

The proposed timeline provided in Appendix B was designed to allow for a large number of interactions with carriers to solicit their feedback both before and after key tasks. While the actual level of interaction is not specified in the timeline, Illinois will be able to customize this and provide more or less interaction based on their preference. Additional considerations for designing a stakeholder engagement plan are provided in Section 4 of this report.

Given that the Illinois healthcare market is a large and disparate one, the structure of the stakeholder engagement process will be an important one. Although the market is disproportionately weighted toward one large insurer with five insurers providing a majority of the coverage, every effort should be made to provide a forum for feedback from all carriers regardless of size. One goal of many of the programs being implemented by HHS is to ensure that small carriers are not pushed out of the market by the risk of anti-selection. In Massachusetts, it has been reported that the smaller carriers are the ones most pleased with the reinsurance arrangement.

2.5 Coordination with MLR, Risk Corridor, and Other ACA Provisions

There has been considerable discussion regarding the interaction of reinsurance, risk adjustment, minimum loss ratio requirements, and risk corridors. These programs, their interdependencies, and expected payment timing are discussed in more detail in section 8.2 of this report.

In summary, reinsurance and risk adjustment are expected to be implemented in the same year that insurance is provided – i.e. program payments will begin in 2014 for risks insured by carriers in that time period. Risk Corridor is a federal program and will be considered after all of the above payments have been considered. While complicated due to timing issues, rate reviews and MLR regulations should be completed including cashflows from all three of the above programs to the extent possible. The final rules require risk adjustment and reinsurance activities to be completed by June 30th of the year following (i.e. June 30th 2015 for 2014). This actually conflicts with proposed risk corridor and MLR timing, but HHS has indicated in the final rules that they are working on a solution.

Section 7.5 provides additional details on timing for the two key programs discussed in this report- reinsurance and risk adjustment.

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3 Factors in Key Decisions

States need to make a number of key decisions with respect to the risk adjustment and reinsurance provisions of the ACA with timelines as laid out in Section 2.2 above for Illinois. Decision areas that fundamentally affect the level of effort and timing of these programs are included below, listed roughly in order of importance. Decisions will generally be driven by the specifics of the state's health insurance marketplace both pre and post reform, the level of stakeholder engagement, different stakeholders' perspectives, the state's goals and resources, and the availability of the necessary data.

3.1 Program Responsibility

The final rules allow states to manage their reinsurance program if the state is also operating an Exchange or to defer operation to HHS (the option to defer to HHS is a change from the proposed to the final rules). If a state is not operating an Exchange, they can still manage the reinsurance program or let HHS administer it. Risk adjustment is similar in that local operation of an Exchange allows that state to also utilize a methodology different than the federally prescribed one. States may also allow HHS to administer the risk adjustment program even if they have a state-based Exchange. The table below reflects the final rules for purposes of clarifying the various options available and to reinforce the markets to which each program applies.

Table 4: Program Responsibilities for the 3Rs

ACA Provision	Sold within Exchange		Sold Outside Exchange			Who Administers	
	Individual	Small Group	Individual	Small Group	Grand-Fathered	State Run Exchange	Federal Run Exchange
Risk Adjustment	Yes	Yes	Yes	Yes	No	State or HHS *	HHS
Reinsurance	Yes	No	Yes	No	No	State or HHS *	State or HHS *
Risk Corridor	Yes	Yes	Some **	Some **	No	HHS	HHS

* State can decide to administer or allow HHS to administer. If HHS administers, all parameters will be federal
**Risk Corridor will apply to QHPs sold outside the HIX that are substantially the same as those sold within the HIX

There are a number of important issues that go into the decision to manage one or both of these programs. The level of resources required to administer this complex program and the availability of data (i.e. through an APCD) are very significant issues, especially for risk adjustment. In addition, the state's (and other stakeholders') desire to control these programs, particularly risk adjustment, may drive the state toward taking on this responsibility. If Illinois

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decides to have HHS administer the risk adjustment program, work by the State required in 2014 and beyond decreases considerably. However, as discussed in section 2.3, the work necessary for carriers to price products in 2014 and 2015 does not change significantly with knowing if HHS versus the State will administer these programs. Issuers need information on the impact of risk adjustment and reinsurance to develop pricing for 2014 and 2015, and HHS will not be able to provide significantly detailed information prior to 2014. The resources necessary to manage reinsurance are lower than those required to manage risk adjustment, but are still significant.

Wakely makes the following recommendations specific to Illinois. These recommendations would not necessarily be the same for other states.

- We recommend that Illinois not administer the risk adjustment or reinsurance programs for the 2014 plan year.
- If Illinois will not have an APCD that collects reliable 2014 plan year data for all fully insured small group and individual market members, we do not recommend administering risk adjustment for plan year 2015.
- If Illinois will have an APCD in place in 2014, State administration of risk adjustment for plan year 2015 would be feasible. There are advantages to having Illinois administer the risk adjustment program, but it would be a complicated endeavor for Illinois, with an untested APCD, several carriers involved, and a lack of experience with risk adjustment programs in general. Carrier input is important to this decision, and interviewing carriers was outside our scope of work for this report. However, based on our knowledge of Illinois-specific considerations, we do not currently recommend that Illinois administer risk adjustment for the 2015 plan year.
- We recommend that Illinois consider administering reinsurance for the 2015 plan year. While it is easiest for the State to allow HHS to administer the reinsurance program, having Illinois administer alternative assessments and parameters for reinsurance recoveries may lower the rate shock for the individual market in 2015, 2016, and beyond, perhaps making it a worthwhile proposition for Illinois.
- We recommend that Illinois perform risk adjustment and reinsurance simulations in early 2014 to assist plans in pricing their 2015 products.

Presented below are the primary advantages and disadvantages that Wakely has identified in pursuing either a federal or state based management of the risk adjustment program. They are based on Wakely's current understanding of the most recent HHS guidelines and proposed timelines.

3.2 Federal or State Risk Adjustment Model and Key Technical Issues

Although Illinois currently plans on allowing HHS to manage their risk management program, it is still important to understand the key parameters that will comprise the federal model. This is

due to the fact that the State will likely hear from their Stakeholder group as to issues related to submitting data to HHS, or the "fairness" of certain methodological decisions. Under HHS management of the program, Illinois will have no capacity to minimize or assuage any of these concerns.

Risk adjustment programs require a risk adjustment model. The final rules indicate that HHS will release a federal model in October 2012. States that want to use an alternative model[1] need to submit it to HHS for review in November 2012, with HHS proposing a maximum two-month turnaround for their review (by January 2013). States considering incorporating an alternative model for plan year 2014 would have needed to have analyzed alternative models by now, due to the short time period between the release of the federal model and submission of state alternative models to HHS for approval. Other hybrid options include using the federal model, but making fundamental changes to it like recalibrating the risk weights or using the model's output differently than proposed under the federal risk adjustment methodology. These changes would also require federal approval, with the assumption that the approval process would be less difficult. There will be similar timelines for subsequent plan years, which would be more pertinent for Illinois. For example, States that want to use an alternative model for the 2015 plan year need to submit it to HHS for review in November 2013, with HHS proposing a maximum two-month turnaround for their review (by January 2014).

In addition to the choice of the risk adjustment model (i.e. the software tool), if a state decides to pursue an alternative risk adjustment program, there are other key technical decisions which would need to be made, including the following:

a) Prospective vs. Concurrent/Retrospective model
b) Include pharmacy categories or not
c) Data fields to be used (e.g. first five diagnosis fields versus all available)
d) Benefit carve-outs (riders)
e) Rating variables and rating variable integration
f) Area calculations and adjustments
g) Scoring for members with insufficient experience

As mentioned above, a detailed discussion of these technical considerations is outside the scope of this paper. Please contact the authors directly and review other available resources for further information on these issues.

In summary, the following list outlines the advantages and disadvantages of the State choosing to administer risk adjustment.

[1] A number of risk adjustment models are currently being used for risk-adjusted payment in Medicare, Medicaid and other public programs including Medicare's HCC, CDPS, MedicaidRx, ACGs, ERGs, and DxCG. Others have been developed specifically for reform programs including Milliman's MARA, Johns Hopkins' ACG reform model, and Wakely's WRA model.

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Advantages to state management

- State maintains autonomy and control over the program, particularly in the view of carriers and consumers.
- Ability for state to set risk adjustment methodology that stakeholders may feel better reflects their specific market and their primary market concerns, etc. For example, the best method for the establishment of a baseline premium (e.g. by state or nationally) could vary significantly based on whether a state is dominated by one carrier that offers statewide coverage, or has a market full of smaller, regional carriers.
- The ability to set state-specific methodologies could also be advantageous as the state spends more time analyzing the risk profile of the newly insured members moving to the commercial market in 2014 and 2015.
- In the event that HHS decides to allow a pharmacy-based "interim model" in the early years of risk adjustment, this may be available only to states that file an "alternative methodology" in 2012 or 2013.
- The State is likely in a better position to review and assess the appropriateness of results from risk adjustment, given their knowledge of the market. Given concerns that risk adjustment could be prone to manipulation, or incomplete data submission, especially in 2014, this local oversight may be important. For example, if a State sees results indicating that the largest carrier has half the risk score that other carriers have, the State may realize that a significant amount of data was missing for the largest carrier. A State in that position may request a re-submittal of claims data; however, such a request is unlikely to occur if the program is administered by HHS.
- Given the role that risk adjustment may play in determining the adequacy of premiums, it is preferable for the state to better understand the program details.
- There may be other entities at the state level that can be leveraged to lower overall administrative costs across numerous programs.

Disadvantages to state management

- It should not be under-estimated as to how much administratively simpler it will be from the State's point of view to allow HHS to manage this process – both from the viewpoint of the large amount of data as well as developing policies and procedures.
- State may not need to be concerned about managing what could be enormous amounts of data.
- State doesn't have to worry about the fiduciary responsibility of collecting large sums of money for later distribution.

3.3 Federal or State Reinsurance Parameters

Regarding the federal temporary reinsurance program, states can use the federal reinsurance parameters or develop state-based parameters. While the contribution rate (what all issuers and TPAs will contribute to fund reinsurance) will be set uniformly on a national basis, HHS is

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expected to publish federal reinsurance parameters based on the market characteristics of each state rather than publishing one set of federal parameters.

The primary issue that will drive each state's reinsurance parameters is the relative size of the projected non-group market in 2014, 2015 and 2016. The smaller the non-group market, the more reinsurance recoveries are available per person covered. If the non-group market is smaller, the parameters could be changed to generate more generous recoveries. Another consideration is that some states may have an expected mix of healthy and sick individuals that is different than the national average or assumed by HHS. In addition to the federal contribution rate, key reinsurance parameters that will be defined around mid-October of 2012 are as follows:

a) Attachment point: The threshold above which claims can be ceded for reinsurance reimbursement.
b) Maximum coverage level: The upper threshold of reinsurance coverage. Claims cannot be ceded above the maximum coverage level.
c) Coinsurance level: The percentage of reimbursement on ceded claims.
d) Method for handling claim payments in excess of assessments: If claim amounts reimbursed are greater than the assessments collected, will HHS not reimburse the last claims requested, or will all claims be paid as a certain percentage (less than 100%)?
e) Method for handling assessments in excess of claim payments

It is expected that states wanting to file either contribution rates or parameters different than the federal ones must respond to HHS by November 2012. Final notice of federal factors will be in January 2013, with states altering these needing to provide public notice no later than March 2013 for use in 2014.

Preliminary modeling suggests that the assessment on issuers will be in the range of 1.0% to 1.5% of premium (1.0% to 1.5% of costs for self-insured) in 2014 for the reinsurance only portion of the assessment. While reinsurance assessments will be collected from a very large base – individual, small group, and large group markets, both fully insured and self-funded – only the individual market can collect reinsurance claim recoveries. Therefore, the individual market premium rates in Illinois may decrease because of this transfer between 9% and 14% in 2014 depending on a number of factors[2]. These estimates are preliminary and assume that the amount of reinsurance contributions on Illinois plans will be paid out in total to individual market carriers ceding claims. Values for 2015 and 2016 are roughly proportional to the 2014 figures listed here, based on the amount of reinsurance funding required by the ACA. In 2014, $10 billion is required to be collected from all states, $6 billion in 2015, and $4 billion in 2016. Therefore, the 2015 premium impact figures are approximately 60% ($6B / $10B) of the 2014

[2] Factors include whether the small group and individual markets will be merged, the reinsurance parameters outlined by HHS, and the size of the individual market in 2014.

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premium impact figures noted here, and 2016 figures are approximately 40% ($4B / $10B) of the 2014 figures.

The three reinsurance parameters mentioned here (attachment point, maximum coverage level, and coinsurance level) will have different effects in different states. Without having detailed claims information for the Illinois market, it is difficult to know how the Illinois market compares to issuers nationwide in terms of distribution of claims costs. Thus, the simulations discussed in section 3.4 of this report become important. The main intent of reinsurance simulations will be understanding the proportion of claim costs in the Illinois' individual market that are more than the attachment point and more than the maximum coverage level. For example, if Illinois' individual market has a large volume of claims, but none reach the attachment point to be established by HHS, then Illinois will receive no reimbursements (but carriers will still need to pay the associated premiums). However, if a large proportion of Illinois' claim costs are between the attachment point and the maximum coverage level, then Illinois' individual policies have a greater opportunity to receive higher reinsurance payments.

3.4 Analysis and Simulation

Issuers will be faced with significant uncertainty with respect to pricing their products in 2014 because of the significant changes under the ACA, including the impact of the risk adjustment and reinsurance programs. When issuers experience uncertainty, they often increase rates or simply choose not to offer products in that market, either of which will protect their organizations from exposure to excessive financial risk – either of which is undesirable from a state and, ultimately, a consumer perspective.[3] No matter how much analysis is completed prior to 2014, significant uncertainty will still exist. However, analysis can be performed which will lessen the uncertainty associated with the risk adjustment and reinsurance programs. From an actuarial perspective, this analysis may be necessary for actuaries to issue unqualified rate certifications[4] that will comply with actuarial standards of practice. States and issuers will need to work together to effectively analyze options, make decisions and simulate the impact of various methodologies.

Within this simulation and analysis, the key decision states and issuers will need to make is whether to use a distributed or a centralized approach. A distributed approach means health

[3]Risk adjustment and reinsurance not only lessen issuer (Health Insurance Company) risk, but they also lessen incentives for issuers to target healthy individuals. This represents a fundamental shift in the marketplace, one that benefits individuals who need insurance the most and who can benefit the most from care coordination and medical management.

[4] Most rate filings require an actuarial certification. A qualified opinion is when the actuary cannot make basic statements required of such filings, without including qualifier language. This language is usually undesirable since it means the actuary has reservations of some sort regarding the soundness of the rates or the rates have a higher than typical degree of uncertainty. Qualified opinions often trigger additional review or other actions.

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issuers run the model and provide results to the state (or whoever is processing the methodology), while a centralized approach means health issuers submit detailed data and the state (or the state's agent) runs the model and processes the results. HHS has indicated that the federal model will operate under a distributed approach, being supplied with risk score information by member, while greatly limiting the amount of data detail submitted by issuers.

If Illinois decides to provide interim risk score information to issuers in mid-2014, and if Illinois does not have an operational APCD at that time, Wakely would recommend the use of a distributed method whereby carriers would be required to simulate expected results for both of these programs. The State could also consider a distributed approach to the more complex risk adjustment program and a centralized approach to the more simplified reinsurance program.

Another key decision is how to fund this analysis and simulation. Some states are exploring partnerships with issuer associations given the lack of available state funds, stakeholder interest in this analysis, and timing constraints.

Please see the simulation section (Section 6) for further discussion on approaches and associated timelines surrounding risk adjustment and reinsurance simulation.

3.5 Level of Stakeholder Engagement

While it will be important for states to structure some type of opportunity for stakeholder feedback, each state will need to determine the appropriate level of interaction and input sought from stakeholders. For example, some states may choose to form a stakeholder workgroup, to which many if not all design decisions are delegated. Other states may wish to be more selective in the decisions they delegate or items for which they seek feedback, and may prefer to meet with stakeholders one-on-one. Where individual states fall along this continuum will be dictated by their individual program goals and market structure (and past levels of success with stakeholder engagement). Please see Section 4 for further information on stakeholder engagement.

3.6 Administration of the Programs

A number of decisions will need to be made regarding the responsibility, authority, and operations of these programs. Section 7 describes these issues in more detail.

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3.7 Other Structural Exchange Decisions

A number of other state-delegated decisions may affect the reinsurance and risk adjustment programs including the following:

- Will the state operate a Basic Health Program? This decision will impact the size of the individual market, which in turn will impact the volume of ceded claims for reinsurance reimbursement. Regarding risk adjustment, carriers may need to consider removing the BHP population from their individual market data submitted for simulations.
- Will the non-group and small group markets be merged? The final HHS market reform regulation has not yet been made available. There are currently some questions related to specifics around how the temporary reinsurance program would work in a merged market environment. For example, many people assume that merged market means that premium rates for identical individual and small group policies would be the same. If that is the case, the impact of the temporary reinsurance program on lowering individual rates would be minimized since the impact of ceded claim reimbursements would be spread over individuals and small group plans in determining premium rates.
- Will employer groups of 51-100 be included in small group prior to 2016? If so, information for those groups would need to be incorporated in the small group risk adjustment simulations.
- What employer options will be allowed within the SHOP Exchange? For example, if employees are allowed to choose any plan offered in the SHOP Exchange, there will be more adverse selection regarding the types of plans chosen by healthy and unhealthy people. The expected result of this is that more money would move between carriers (greater charges and payments).

A full discussion of the technical impacts of the above decisions to the risk adjustment and reinsurance programs is outside the scope of this paper. However, it is important that the risk adjustment work plan consider the implications of structural decisions.

4 Stakeholder Engagement Plan

Because the risk adjustment and reinsurance programs are intended, in part, to manage premium costs by allowing issuers to be less conservative when pricing their products, ensuring that stakeholders fully understand and are reasonably comfortable with the methodology adopted by states will be an important element of program success. It is therefore important for states to develop a method and process for communicating with and obtaining feedback from stakeholders at different points in the risk adjustment and reinsurance implementation process. Work with stakeholders will need to touch on both methodological and programmatic

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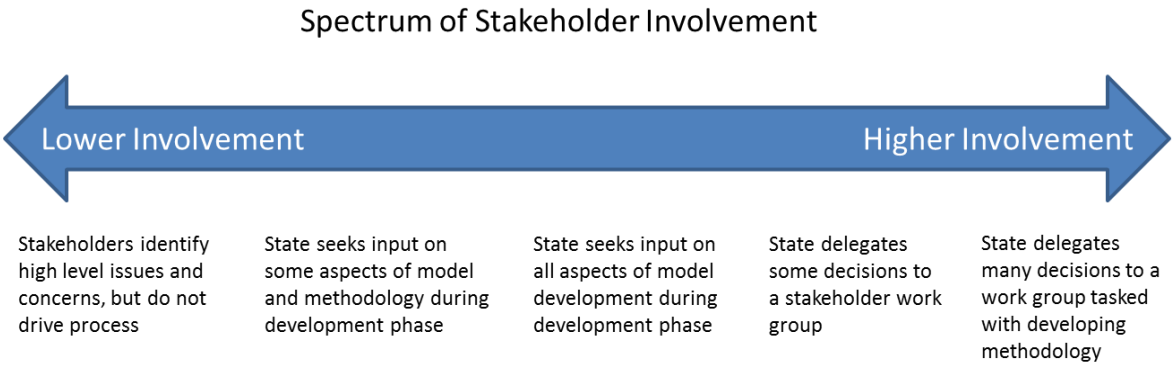
issues, including design elements of the model, as well as items such as the timing of data refreshes, reporting, and payment schedules. Key milestones are listed below.

The following exhibit highlights the choice states will need to make on the level of stakeholder engagement:



4.1 Establish Stakeholder Workgroup

Some states may wish to create a workgroup of stakeholders to help structure input and feedback into the development of the risk mitigation programs. Having such a forum may help consolidate and streamline the process for providing input, as well as provide a forum for discussion amongst stakeholders about their shared and individual concerns and/or goals for the risk mitigation program. For some issues, however, it may be preferable, either for the state or for individual stakeholders, to provide content in written form or via one-on-one meetings.

The key stakeholders for reinsurance and risk adjustment are obviously the issuers since these programs will affect them significantly. However, providers and other state agencies may be interested in participating. Consumers, navigators and others may have an interest, although education and communication may be the most important aspect of engaging these groups.

4.2 Hold Initial Meetings

Including stakeholders early in the process is one approach to make issuers feel that they are part of the process. It could also provide states the opportunity to identify key issues and/or concerns felt in the market with respect to risk adjustment prior to making key design and implementation decisions. Having this information early in the process will allow states to address key issues as part of the program design. Discussion at this point can remain high-level and constitute a sharing of goals, issues, and concerns in the design and implementation of the process, as well as clarification related to the overall timing of key decisions and implementation milestones.

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4.3 Stakeholder Opportunities for Feedback on Model and Methodology

Once they have received initial stakeholder input, a state may elect to provide additional opportunities for specific feedback on program design elements as they are developed. The format for accepting feedback, as well as the depth of input requested, will need to be calibrated within each state to reflect the level of input desired by the state.

Options for soliciting stakeholder feedback include conducting a survey focused on certain design elements or implementation issues; holding one or more open meetings to solicit formal or informal stakeholder feedback; soliciting written feedback, either to specific proposals or general questions; or creating a work group. The work group could contemplate broad or narrow participation and be used to either develop recommendations or to provide structured feedback on state proposals.

4.4 Follow Up Meetings to Review Feedback and Communicate Decisions

Once initial decisions have been made, states will need to develop a way of communicating these decisions to inform stakeholders of the final resolution, elicit further public comment and stakeholder feedback, and provide final opportunities for stakeholders to weigh-in on design and implementation issues. This communication can happen within large or individual meetings, in which the state presents its proposed approach; in a report provided to the market; or in a more formal, regulatory process by issuing draft or final regulations. State communications should make proposed or final design, methodology, and model decisions as clear and understandable to stakeholders as possible to ensure all market participants have sufficient information to make informed pricing and business decisions.

Once a proposed methodology has been selected, an important element of stakeholder communication will be sharing the results of simulations or “dry runs.” This will allow both the state and stakeholders to concretely understand the impact of risk mitigation programs on the market as well as on individual organizations.

4.5 Ongoing Collaboration

The process for risk adjustment and reinsurance development and refinement will not end after the initial risk adjustment and reinsurance decisions have been made and implemented. Once the programs become operational, the state will need to continue an ongoing dialogue with key stakeholders to ensure the programs are working as intended. States will also make any needed improvements or refinements to program parameters or design issues to reflect unanticipated issues and/or new issues that materialize during the operational phase. Such communication could occur through a stakeholder work group, through ongoing opportunity for comment, or through more informal communication channels with key stakeholders.

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5 Scenario Definition

As an accompaniment to this narrative, a sample timeline has been provided to assist Illinois as you contemplate how best to complete work between now and the 1/1/2014 introduction of the state Exchanges. The timeline was derived based on a consideration of a spectrum of state decisions and goals. Appendix B contains the detailed timeline that we believe is most appropriate for Illinois, given the State's current lack of an APCD and limitations in collecting a large quantity of detailed claims data from carriers.

5.1 Key Factors in Timeline Development

The timeline for analyzing and implementing risk adjustment and reinsurance depends on numerous issues that will be specifically defined by each state. Although Wakely has provided target timelines in the appendices, Illinois should review this in greater detail to ensure that they are achievable in your State. The most impactful items that will affect the timeline are:

- The state's access to detailed claims data through an All Payer Claims Database (APCD). States that have implemented or are in the process of implementing an APCD would most likely have access to detailed claim data, as long as the APCD was not developed for a specific, different intent with limitations on possible uses. States without an APCD may also have access to data through a specific data request to issuers, which has been assumed for purposes of the timeline shown in Appendix B for Illinois. (This course of action is covered in more detail in Section 5.2 below and the companion document containing the data request for issuers);

- The state's interest in exploring an alternative to the federal risk adjustment model ("state alternative"). Wakely has assumed this will not happen for the 2014 plan year, but may occur for the 2015 plan year;

- The state's interest in developing reinsurance parameters different than the federal parameters, particularly for the 2015 plan year;

- The number of issuers participating in Illinois' individual and small group commercial markets, which will negatively affect timelines for Illinois given the large number of carriers in the state;

- Available funding for risk adjustment and reinsurance analysis, stakeholder engagement, and simulations; and

- Issuers' willingness to provide data under a centralized approach or to model results under a distributed approach. As discussed above, a methodology of centralized for reinsurance and distributed for risk adjustment would allow Illinois a reasonable balance of minimizing detailed data collection on risk adjustment and maintaining more decision-making power on reinsurance.

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5.2 Timing Considerations

Setting up any scenario involves working around deadlines in the final HHS rules as follows, which are less onerous if only pursued for reinsurance and not risk adjustment. These dates reflect preparation for the 2014 plan year, and are expected to remain the same for each subsequent plan year (each date should be advanced one year forward):

- October 15, 2012: HHS is scheduled to release the federal risk adjustment model and reinsurance parameters.
- November 15, 2012: Date for states that want to submit an alternative risk adjustment methodology or alternative reinsurance parameters to submit the model and/or parameters to HHS.
- January 15, 2013: Date HHS will respond to states that submitted alternative risk adjustment methodology or alternative reinsurance parameters.
- March 1, 2013: Communicate the 2014 Notice of Benefit and Payment Parameters
- October 1, 2013: Products and premiums effective in 2014 are publicly available; enrollment begins

In addition, the following timing considerations are critical components of developing timelines for all scenarios:

- April 2013 and 2014: Issuers, and specifically their actuaries and rate-setting teams, must have time to incorporate the results of the risk adjustment and reinsurance projections. Without adequate time, issuers will likely be even more conservative in developing premium rates. Therefore, it is important for issuers to be given enough time to incorporate key assumptions into their pricing. The authors believe issuers would need to be supplied with sound projections of risk adjustment and reinsurance financial transfers before the end of April 2013. Illinois should validate these dates with their carriers in initial Stakeholder meetings.
- July 2013 and 2014: While rate filing requirements and timing varies greatly between states, issuers in all states will need sufficient time to market 2014 and 2015 products at the new rates. Based on input from issuers, departments of insurance and others, issuers could be expected to be required to submit rate filings for their 2014 plan offerings by about July 1, 2013. Likewise, issuers could be required to submit rate filings for their 2015 plan offerings by about July 1, 2014. Again, this requirement will differ by state, but this assumption has been incorporated into the timeline outlined. Again, this should be verified by Illinois based on their specific deadlines.

Assuming Illinois will not administer the reinsurance or risk adjustment programs for the 2014 effective year, the State still should perform the following:

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- Clearly indicate to carriers by when rate filings will be due
- Communicate expectations regarding the content of the rate filings
- Confirm with carriers that they understand how to incorporate risk adjustment simulation results being performed in early 2013 into their 2014 product pricing
- Determine if the State will proceed with administering risk adjustment or reinsurance programs for the 2015 plan year
- Perform risk adjustment and reinsurance simulations that assist carriers with the pricing of 2015 products

5.3 Scenario Specifications

The sample timeline provided in Appendix B assumes that a specific data request would be submitted to the issuers. The data supplied could be detailed claims information or summarized information. The state, or a state subcontractor, would collect and compile the data provided by the issuers. If detailed data were supplied, the state, or a state subcontractor, could run a publicly available risk adjustment model on the data supplied in order to identify data issues and to obtain preliminary results. Alternatively, if the distributed method is used for risk adjustment, the carriers would supply diagnosis prevalence reports after running a publicly available risk adjustment model, and the results would be compiled by the state.

Even though Illinois has decided to have HHS administer risk adjustment, issuers will still need to understand the financial implications of risk adjustment prior to 2014 so that they can appropriately price their products, making simulations very relevant. This timeline assumes that Illinois issuers will begin submitting data in January 2013 as part of the simulation project performed by Wakely.

One important point to make is that incorporating adjustments for the currently uninsured population to capture their expected risk (morbidity) will be a critical component of these analyses. The timeline provided assumes that the risk (morbidity) and the general claim level of the currently uninsured population would be incorporated. This may be accomplished through the Illinois-specific analysis of the uninsured population and the currently insured markets, which was part of the Wakely market reform analysis performed in 2011. In addition, the Society of Actuaries is currently studying the impact of the incoming uninsured population on either a state-specific or regional basis, with results to be published by the end of 2012. Results of that study should be very informative to Illinois, and can provide an additional reasonability check to other analyses performed regarding the Illinois uninsured market.

6 Analysis and Simulations

In the absence of specific and customized direction at a carrier level, there are concerns that the 2014 pricing will include excessive conservatism due to uncertainty in 2014. While ACA requirements such as minimum loss ratio (MLR) and risk corridor thresholds, as well as general

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competition in the market, are expected to have mitigating effects on high levels of conservatism, a certain degree of conservatism will exist going into 2014. However, analysis can be performed which will lessen the uncertainty associated with the risk adjustment and reinsurance programs. From an actuarial perspective, this analysis may be necessary for actuaries to issue unqualified rate certifications that will comply with actuarial standards of practice. States and issuers will need to work together to effectively analyze options, make decisions and simulate the impact of various methodologies.

As detailed in the executive summary above, pricing actuaries at carriers will need three key pieces of information with respect to the risk adjustment program in order to price their products for 2014 and 2015:

1. What is the risk score of their current enrolled population with respect to the market average?
2. What is the risk score of the currently uninsured population that will become insured in 2014 (most relevant for the non-group market)?
3. What is the average cost of a currently uninsured individual who is expected to join the insurance market relative to individuals currently insured?

In the above questions, risk score and average cost are defined as relative to average members in their rating category (i.e. after accounting for allowable rating variables such as age, smoking status, and geographic area).

Regarding question #1, Illinois carriers have contracted with Wakely Consulting Group to calculate the average risk scores for the small group and non-group markets. Participants in the study represent 86% of the Illinois small group market and 96% of the Illinois non-group market. Therefore, the State does not need to conduct risk adjustment simulations prior to 2014 to assist carriers with the pricing of their products. General information regarding this simulation is available at www.wakelysimulation.com.

However, we recommend that Illinois work with carriers to determine the timing and type of information needed in early 2014 in order to price their 2015 products. As shown in Table 1 of the executive summary, we recommend collecting information on disease prevalence in early 2014.

In addition to the questions related to the risk adjustment program above, pricing actuaries will need to develop an estimate of the impact of the reinsurance program on non-group product premiums. Upon release of the federal parameters in October 2012, existing carriers will be able to analyze their own claims experience to determine the possible recoveries expected in the 2014 plan year. However, carriers will also need to consider if the reinsurance mechanism will collect enough in assessments in order to pay the reinsurance recoveries according to the federal reinsurance parameters. Illinois can assist carriers by accumulating information that

would help inform carriers of the expected overall reinsurance assessments to be collected, compared to the expected recoveries for the overall Illinois individual market. Considering the limited time between now and April 2013 and the fact that Illinois does not have an APCD, we recommend that the State focus on assisting carriers for the pricing of 2015 products in this regard.

If Illinois proceeds to consider administering the reinsurance program for the 2015 plan year, the state will need to perform careful modeling in 2013 to determine appropriate reinsurance parameters. If the parameters are set too conservatively or aggressively, the reinsurance program may end up with excessive reserves or shortfalls, either of which could be detrimental to an efficient market.

Question #3 above is typically included in Level One Establishment Grant proposed activities and is addressed by economists and/or actuarial consultants. An Illinois study discussing questions #2 and #3 was referenced in section 5.3 of this report. The various approaches and key steps for analyzing these concepts are discussed below.

6.1 Market Assessment

In order to begin the process of assessing both of these programs and deciding on the state's involvement, a detailed understanding of the various state markets and uninsured will need to be developed. Through federal Exchange planning grants, many states have performed initial assessments of the impact of the ACA on the various markets, including the impact of previously uninsured entering the market. Wakely, as a subcontractor for HMA, performed an Illinois-specific analysis on market reform in 2011. That analysis incorporated the morbidity differences between the uninsured population and the currently insured markets. Analysis of the risk adjustment and reinsurance programs should be integrated with this analysis to the extent possible.

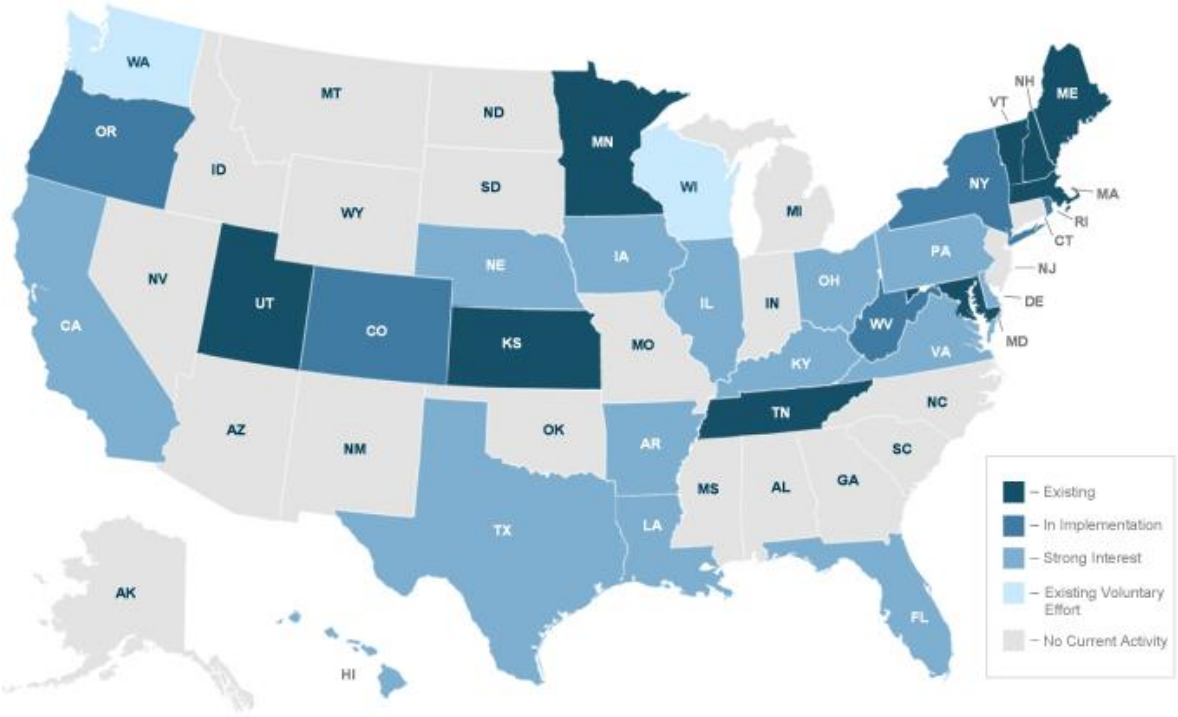
For Illinois, we would expect to more deeply investigate these programs above. The availability of data and modeling including the following should be evaluated:

- Detailed claims and eligibility for the individual and small group markets (i.e. through an APCD).
- Overall market share for each market (non-group, small group, fully insured group, ASO/TPA, Association, and Medicaid), and by health insurance issuer.
- Currently uninsured and changes in uninsured rates (separated into commercial and other public program migration), high risk pool participation and characteristics, and others.
- Current commercial reinsurance levels for the individual market.
- The availability of rate filings to review current premium levels and rating parameters.

Simulations for both of these programs face a substantial amount of uncertainty due to changes in the insurance markets that will occur beginning in 2014. The introduction of the state Exchanges in 2014 will cause movement between market segments, which will be complex to predict based on the large number of factors that will drive consumer behavior. This is contemplated as an integral part of the second simulation.

6.2 Status of All Payer Claims Databases (APCDs)

The status of available data will factor into the feasibility of a given work plan for a state, and is therefore important to review in the preliminary analysis. The following table presents the status of efforts around APCDs by state. [5]



As Illinois does not have a currently existing APCD (or one in implementation), and considering the limited time until the state alternative approach would need to be submitted for approval, having HHS administer risk adjustment for the 2014 plan year is the only feasible option. Even for states that have existing APCDs or ones in implementation, seeking exception from minimum data collection rules would involve providing technical specifications and proposed

[5] Source: APCD Council (www.apcdcouncil.org/).

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modifications to support risk adjustment and other claims-related activities (HHS 45 CFR 153). The existence of an APCD is less vital for reinsurance.

There are several key questions to be considered if an APCD is to support risk adjustment. The list below is not meant to be exhaustive, but merely to provide a sense of the basic elements needed for implementing a risk adjustment program.

- Data availability: The APCD must have at least a year of data to be useful. The timing of data submission to the APCD and when data become available for use are also important.
- Data format: If a state does not expect to have an operational APCD by January 2013, the data that are collected from payers will be subject to minimum data collection rules. The minimum data collection rules specify X12N 837 / NCPDP (pharmacy) format for encounter data submission, and the X12N 834 format for enrollment data.
- Eligibility Elements: There are several elements required for proper risk adjustment, and the full list would vary based on the risk assessment tool that is used. These include (at a minimum):
    - Unique member identifier that needs to be consistent across claim and enrollment information, as well as across products within an issuer and across issuers. Typically, consistent identifiers such as Social Security Numbers (SSNs) are submitted by issuers to a warehouse where they are encrypted into a different yet still consistent and unique ID.
    - Coverage spans that allow calculation of months of eligibility by coverage type and also distinguish whether or not the individual had a medical/pharmacy benefit during that time. Risk assessment tools typically take into account partial months of eligibility so that the scores are not biased.
    - Age, gender, coverage type and other demographic information.
- Claim Elements: Risk assessment tools typically vary in terms of what information is required from encounter data in order to run the software. Some widely used adjusters require very little information to run - namely diagnosis codes, national drug codes (NDCs), service dates (in order to correctly identify experience periods), unique member identifier, and procedure codes (CPTs). Procedures codes are typically not used in the adjuster software itself. However, they are valuable in excluding diagnosis codes from diagnostic services that introduce false positives and are therefore susceptible to gaming.

The following tables highlight key information required by risk adjustment and whether existing APCDs currently contain this information.

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Table 5: Status of key fields related to risk adjustment (MA, ME, VT, TN, KS)

Description	Massachusetts	Maine	Vermont	Tennessee	Kansas
First service date available in APCD	Jan 2008	Jan 2004	Jan 2007	Jan 2009	At least 2004
Level of edits / checks employed for acceptance (Low, Medium, or High)	High	med-high	med-high	At least medium	At least medium
Level of checks employed after acceptance for use (Low, Medium, or High)					
Data Element Inclusion					
Required demographic fields captured (age or DOB, gender, region or zip code)	Yes	Yes	Yes	Yes	Yes
Can connect eligibility and medical claims with unique member ID	Yes	mostly	mostly	Yes	Yes
Can connect eligibility and pharmacy claims with unique member ID	Yes	mostly	mostly	Yes	Yes
Can create eligibility spans	Yes	Yes	Yes	Yes	Yes
Number of diagnosis codes collected (maximum)	13	13	13	13	9
Pharmacy data included	Yes	Yes	Yes	Yes	Yes
Pharmacy NDC Code included	Yes	Yes	Yes	Yes	Yes
One record per coverage *span* or for each month of coverage	Per Month	Per Month	Per Month	Yes	Yes
Status information like disability included (include footnote with references)	No	No	No	No	No

Table 6: Status of key fields related to risk adjustment (UT, MN, MD, NH)

Description	Utah	Minnesota	Maryland	New Hampshire
Date APCD was or will be available	2010	July 1, 2009	Varies[1]	2005
First service date available in APCD	Jan. 2007	At least Jan'08		At least 1/1/2005
Level of edits / checks employed for acceptance (Low, Medium, or High)	At least medium	At least medium	Low-Med	High
Level of checks employed after acceptance for use (Low, Medium, or High)				
Data Element Inclusion				
Required demographic fields captured (age or DOB, gender, region or zip code)	Yes	Yes	Yes	Yes
Can connect eligibility and medical claims with unique member ID	Yes	Yes	Partially[2]	Yes
Can connect eligibility and pharmacy claims with unique member ID	Yes	Yes		Yes
Can create eligibility spans	Yes	Yes	Yes	Yes
Number of diagnosis codes collected (maximum)	8	12	Yes	13
Pharmacy data included	Yes	Yes	Yes	Yes
Pharmacy NDC Code included	Yes	Yes	Yes	Yes
One record per coverage *span* or for each month of coverage	Yes	Per Month	Per Coverage	Per Month
Status information like disability included (include footnote with references)	No	Yes[3]		

1. Medical data available since early 1990s, pharmacy added around 2000, eligibility added in 2011

2. Not able to track movement across products / plans.

3. Product code indicates 'disability' or 'disability benefits'

6.3 Risk Adjustment Simulations

As noted above, simulations for both of the programs being reviewed face a substantial amount of uncertainty due to changes in the insurance markets that will occur beginning in 2014. Most difficult to capture is the effect of the introduction of the state Exchanges in 2014 on movement between market segments, which is difficult to predict based on the large number of factors that drive consumer behavior. As discussed previously, the State does not need to perform risk adjustment simulations for the 2014 plan year since the majority of carriers in Illinois have contracted directly with Wakely to provide this information. However, this section of the report is still useful for the State to understand what carriers will be using to develop their 2014 premiums and as considerations for the potential of the State administering risk adjustment simulations early in 2014 to assist with the 2015 product pricing.

A centralized approach to simulations means that a central agency would run the risk adjustment simulations using detailed claim and eligibility data. A distributed approach would still require a central agency to perform many of the functions of a simulation. However, instead of the central agency running detailed claim and eligibility data through a risk adjustment model, issuers would run the model and provide member level or summary level results to the central agency. Although Illinois is not contemplating a centralized approach, both methods are presented below for purposes of understanding the key options available.

Centralized Approach

A centralized approach to risk adjustment simulation would generally require an existing APCD or a fast moving collaborative effort on the part of issuers to supply detailed claim and eligibility data. This approach would require the state to run the data through a risk adjustment tool and produce reporting, some of which would be shared with the plans. The risk adjustment methodology currently administered by HHS for the Medicare Advantage population is a centralized approach in which participating carriers provide HHS with detailed encounter data for each covered beneficiary. The minimum data required to run a typical risk adjustment tool are discussed in our companion Data Call document.

Centralized simulations would require more resources from the administering entity. The entity could develop the capability (i.e. staff, equipment, licensing, etc.) to run the risk adjustment analytics or hire external expertise. The main steps involved would be:

- Engaging issuers, collecting detailed eligibility and claim data, and premium data and rating factors
- Applying checks, thresholds, or edits to data, ensuring consistency in formats
- Loading data into a database system
- Preparing input files for a risk assessment tool
- Running the tool and producing detailed risk reports broken out by (amongst other things) market segment, plan, and demographic/eligibility categories

As discussed earlier, the main purpose of simulations is to inform pricing of products in 2014 and 2015. While the rate filing deadline may vary by state and/or products, it is assumed for the purposes of timelines in this paper that the deadline for filing rates would be in July 2013 for the 2014 plan year. This means that information from simulations would need to be shared with plans as early as April 2013. In a centralized approach very detailed reporting on the underlying morbidity risk of the covered population would be available to the Exchange. This information would be useful for a variety of purposes; for example, producing risk adjusted cost and utilization metrics, planning for future Exchange initiatives, monitoring levels of adverse selection within the Exchange and financial impact to issuers, and preparing for any disruptive changes in access of care. However, the information that needs to be provided to plan pricing actuaries would be limited to the overall relative risk profile (possibly at other levels of detail

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including product or network and area). Issuers should also be provided with reporting showing the drivers of differences from the average risk (for example, a higher prevalence of individuals indicated with cardiovascular disease).

Another purpose of a simulation is to inform the decision on whether to use the federal risk adjustment methodology or an alternative methodology. This, of course, assumes that a state is considering an alternative methodology. Interest in an alternative methodology may be driven by a number of factors including what data to use, factors to apply, timing, phased in approach, etc. The very first round of simulation using an alternative model would give the state information on whether this approach would be feasible. For example, if the cost of running the analytics is too high, or the data are inadequate, or the model produces inconsistent or unreasonable output – the state may decide to discontinue with the alternative model approach. In a centralized approach, on the one hand, the state could apply the alternative methodology more consistently across issuer data; however, it would consume time and resources.

Conversely, the state may decide that this is the approach they wish to pursue for the 2015 plan year, and prepare to submit an application to HHS to certify the alternative methodology in early November 2013.

Distributed Approach

A distributed simulation approach would not require an existing APCD or issuers to submit detailed claim and eligibility data. However, this approach would not allow the state to validate the data by comparing it to benchmarks or comparing it across organizations. Certain methods could be employed to lessen these issues, but there would likely be bigger concerns compared to the centralized approach. The more detail provided by issuers under this approach, the higher the quality of the results and understanding of the results would be. For example, if issuers returned member-level information including risk markers for each member, the state could not only tell each issuer how their overall risk profile compared to the market average, but they could tell each issuer what was driving differences in the average (for example, a lower prevalence of diabetes or a lower prevalence of individuals taking medications associated with heart disease). There are some concerns in the industry that gaming or fraudulent practices could be encouraged under the distributed approach since disease prevalence, rather than detailed encounter claims, would be provided by the carriers. However, this concern is greatly minimized since there are requirements to audit risk adjustment results; gaming and fraudulent activities should be discovered in audits, as is done today in "RADV" risk score audits performed by HHS for Medicare Advantage beneficiaries.

The distributed simulation approach would require access to a risk assessment model by all plans submitting this information. Ideally, the access should be free of cost and should minimize administrative burden to the state, which is a key consideration in approving an alternative methodology. To the extent the model is easy to understand, simple to use, and transparent, it

would help ensure appropriate application across plans. The model should provide diagnostics on each run so that any obvious errors are promptly identified. Such diagnostics can include the proportion of individuals not grouped in any category, percentage of members with medical encounters and/or pharmacy encounters, the average length of eligibility of a member in a calendar year, the proportion of diagnostic diagnoses excluded from scoring, etc. Additionally, any model that operates on elements that are fairly consistent across issuers would be better under this approach. For example, the meaning of a diagnosis code does not change across issuers, however if an approach makes a distinction between professional and inpatient codes, the way these services are categorized may vary across organizations and introduce a layer of uncertainty in results.

This approach can include requiring a certification from the plan actuary regarding the appropriate use of the model and furnishing information that is accurate and complete to the best knowledge of the actuary. This may increase the likelihood of obtaining data that has undergone more review and scrutiny.

6.4 Reinsurance Simulations

The goal of reinsurance simulations is to ensure that the national contribution rate will appropriately cover projected reimbursements. This will allow a state to draw its own conclusions about the adequacy of the national contribution rate, and ultimately drive a decision by a state as to whether or not they should alter the federal assessment rate and create a state-specific assessment. According to the HHS rules, states have the option of increasing the assessment due to concerns about inadequacy or the desire to fund administrative expenses, but may not decrease it. They can also alter (or remove) certain reinsurance parameters. The actual surplus/deficit of the program realized will also be heavily influenced by the risk profile of its residents in the individual market which drives the level of claims being reimbursed in the state. We are assuming that Illinois will not have time to gather the necessary information for reinsurance simulations prior to mid-2013, which would have assisted carriers in pricing their 2014 products. However, mid-2013 and annually thereafter, the reinsurance program projections should be reviewed in-depth to ensure fiscal soundness.

The first simulation would model projected cash flows of the reinsurance program with static population estimates and parameters proposed by HHS. It is expected that relative health of the residents enrolling in individual plans will have a major effect on the level of reinsurance that can be afforded by the parameters. All else being equal, if a state's individual market enrollees have a higher risk profile relative to the nation as a whole, then the average federal contribution may result in much lower parameters than other states. The second simulation contemplated in the timeline will focus on incorporating expected population migrations as a result of the ACA. Key considerations in projecting post-migration program expenses are heavily dependent on the following assumptions:

- Current proportion of health insurance premiums (fully insured) or medical claims (self-funded) in the individual market versus all insurance markets including individual, small group, large group, self-insured groups, Medicaid managed care, Medicare managed care, and others. The larger the current individual market share relative to the overall market, the lower the reinsurance levels afforded by an average contribution. Illinois is in line with the United States average in terms of the current individual market share relative to the overall market[6].

- Similar to the above, states with a greater than average proportion of currently uninsured residents would drive an even higher proportion of individual insurance market premiums in 2014. This rapidly expanding individual market in 2014 would result in less money available for claims reimbursement, thus lowering the overall effect of the reinsurance contributions on that market. This may be a function of the attractiveness of the individual market plans offered in the state Exchange and their ultimate level of subsidies, which is beyond the scope of this review.

- Rate of expansion of the public programs and integration of such plans within the state Exchanges could also alter the premium proportions by market segment. If more of the uninsured have the ability to move to public programs, then this will decrease individual market costs which will affect coverage options.

The simulations contemplated above should be conducted as frequently as possible to monitor the potential for a deficit emerging in that first year. The frequency of calculations for 2015-16 will be dependent on the state's preferences and the accessibility of data from the reinsurance administrator and/or market issuers. These reviews will need to continue through 2018 as this is how long the pools will remain open, although the final years would only entail a projection and estimate of runout claims, not assessments (unless the program were extended as proposed rules allow). There could also be questions as to the eventual use of any surplus left over at the end of the program, given that Incurred But Not Reported (IBNR) reserves starting in the end of 2016 will need to be conservative to allow for the variability in late-reported claims.

Here is how Illinois can use the results of simulations and actual mid-year tracking of results:

- If Illinois discovers that deficits are likely to occur while conducting simulations, alternative parameters could be submitted for future years that would reduce the claims submitted. This would be applicable if Illinois chooses to administer the reinsurance program.
- If Illinois discovers that deficits are likely to occur within the effective year based on known assessments and actual claims submitted, the following options could be taken:

[6] http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=15&ind=125&sub=39

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- Recoveries could be adjusted for all outstanding claims submitted for the remainder of the year such that after adjustment, deficits would not be expected.
- Recoveries could be paid on a first-come-first-serve basis. Once the assessment revenue is exhausted, recoveries cannot be distributed.
- Illinois could have a permanent rule to only pay out a certain percentage, say, 75% of the submitted claims, and then at the end of the year, pay out the remaining funds according to what was previously submitted. Under this approach, the State may reimburse only 95% of the submitted claims, but all claims would have been adjusted by the same percentage.

- If deficits are expected to occur, the information should be shared with the carriers so they can incorporate that information in their product pricing for the following year.
- The current regulations do not provide much insight into the possibility of the reinsurance program ending with a surplus at the end of 2018 (through the 2016 plan year). For states that have HHS administer the program, the federal parameters determining recoveries will be changed annually with the intention that in the final plan year of the program, a surplus will be extremely unlikely. In the unlikely event that such a surplus would occur, the following possibilities could be considered:
  - If Illinois has a state-based Exchange, the surplus could be paid to the Exchange to help offset future administrative expenses. We recommend that this approach be taken if possible.
  - The surplus could be used to reimburse reinsurance claims in future years, but only if the State administers the program and if the surplus is generated from the additional amount of assessments beyond the HHS-required amounts.

6.5 Key Simulation Deliverables

Simulations are intended to provide key information to carriers and the State in order to make decisions on several topics including pricing and program management. We believe there is not enough time for Illinois to perform simulations to inform decisions for the 2014 plan year. As mentioned previously, most of the Illinois small group and individual markets are funding a currently ongoing simulation specific to risk adjustment which is designed to assist them price their 2014 products. For future plan years, Illinois may want to consider performing simulations particularly if the State is considering alternative reinsurance parameters or intending to assist the carriers apply appropriate adjustments for these programs in their 2015 product pricing.

The following is a list of deliverables that may be available to carriers based on the specific simulation analyses performed.

For risk adjustment:

- Report illustrating the results of applying a risk assessment model on collected data from issuers. The results include an average risk score for issuers which allow for simulation of risk adjustment payments. Detailed results would include prevalence statistics and data diagnostics that would provide further insight into drivers of risk and data quality. Summarized relative risk scores provide critical input toward actuarial pricing of health insurance products in 2014 and 2015.

- Expected payable/receivable adjustment by carrier. This involves applying the risk score factor output mentioned above and normalizing for ratable factors (e.g., age). This also involves incorporation of baseline premium with possible adjustment for items such as geography and actuarial value of plan designs.

- Recommendation on whether or not to utilize a state model versus the federal model, and whether to administer the program locally. Due to timing, we recommend that Illinois have HHS administer risk adjustment and reinsurance for the 2014 plan year. However, Illinois could make this decision in the summer of 2013 for the 2015 plan year.

- If Illinois administers the risk adjustment program, simulations could provide explicit identification of expected deficit/surplus projected from risk adjustment, if expected. These amounts could then be factored into the following year's contribution rate to be included in reports for late 2015-16 starting in late 2014.

- Publication of the risk adjustment model proposed to be used. The federal government proposes that states that plan to modify federal parameters (national in scope) issue their notice by early March in the calendar year before the effective date.

From the reinsurance side, output associated with the simulation would include the following:

- Report to state entity governing reinsurance on expected range of financial results under various scenarios for premium levels, national premium assessments, migration assumptions, reinsurance parameters, and health status.

- Recommendation on whether or not to create a state-specific assessment rate based on factors identified above based on range of likely results.

- Explicit identification of expected deficit/surplus to be factored into the following year's assessment will eventually have to be included in the report as well.

- Estimate of IBNR for the program.

- Publication of assessment rates different than national rates is required. The federal government proposes that states that plan to modify federal parameters issue their notice by early March in the calendar year before the effective date.

6.6 Filing with HHS

The HHS rules included minimum criteria for a state-based risk adjustment methodology. States can also modify the reinsurance parameters, but may not modify the structure of the reinsurance coverage. As discussed previously, this is likely to be more relevant for Illinois with respect to the less complex reinsurance program.

HHS rules provide some minimum criteria for the model, including performance similar to or better than the federal model. If a state decides to develop its own risk adjustment model or adjust the federal weights, it needs to do so at least as often as the federal model is updated.

State models must meet criteria based on principles that guided the creation of the hierarchal condition categories (HCC) model used in Medicare Advantage risk adjustment, including:

1. Accurately explains cost variation;
2. Chooses risk factors that are clinically meaningful to providers;
3. Encourages favorable behavior and discourages unfavorable behavior;
4. Uses data that are complete, high quality and available in a timely fashion;
5. Provides stable risk scores over time and across plans; and
6. Minimizes administrative burden.

HHS is requiring risk adjustment activity reports in the year after the benefit year showing average actuarial risk for each plan, the charges and payments, and likely additional information. Information might include prevalence reports showing the drivers behind differences in the results and normalization factors. The authors expect HHS to develop a standardized report, allowing states the ability to include additional information. The report structure would need to be able to accommodate state-specific risk adjustment methods and models.

All of this information will need to be filed with HHS in November 2013 for implementation in the 2015 plan year. While it is possible that changes to the federal model would be released in October 2013, and that may influence an alternative model submitted by the State, most of the information necessary to support the predictive nature of the state's alternative model can be prepared in advance.

7 Administration and Governance

The current regulations contemplate a significant role for states in the administration of both the reinsurance and risk adjustment programs. These functions can be run by the Exchange or by another non-profit entity. In addition, guidance could potentially allow for agencies within the state (other than the Exchange) to administer reinsurance. Funding for the reinsurance

program can be included in the assessment from issuers, meaning no additional state or federal funding will be required to manage the program. However, the risk adjustment program, similar to other ACA responsibilities such as granting exemptions to the individual responsibility requirement, will create an expenditure that must be supported through Exchange funding or another financing source. Of the two programs, the reinsurance program is less operationally complex, while risk adjustment represents a more comprehensive commitment from the state. Key elements and considerations related to the administration and oversight of the risk adjustment and reinsurance programs are discussed in this section.

7.1 Determine Program Governance and Oversight

When establishing a risk adjustment or reinsurance function, Illinois must first decide where the function will reside and who will govern it. Risk adjustment and reinsurance functions managed by the state can be overseen by the Exchange or by another public agency within the state. The decision-making process for establishing a governance structure will be driven both by an assessment of existing capacity for data collection, analysis, and related regulatory oversight functions, as well as a strategic and policy assessment of where these functions best fit within the overall structure of health care reform. The Exchange has a dual role that encompasses functions analogous to a private company as well as regulatory and oversight functions more similar to a government agency. Although at times advantageous to play both roles simultaneously, finding the appropriate balance can be challenging. Some states may elect to combine both types of functions within the Exchange; others may seek to differentiate purely regulatory functions from more market-oriented functions.

The core competencies required for administration of these programs include, but are not limited to the following:

- Policy making ability for such tasks as issuing regulations and determining new rules as needed;
- Program management such as setting program parameters, monitoring compliance, and managing underage or overage of assessments versus payments;
- Financial acumen to analyze ongoing results, review and revise program parameters, or interface with external consultants that are actuaries who are responsible;
- Managing key accounting functions such as cashflow, reporting to carriers, monitoring the reimbursement fund levels;
- Operational capabilities to collect assessments from a wide variety of payors including carriers, MCOs, and even TPAs;
- Operational capabilities in collecting and re-distributing risk adjustment payments;
- Insurance acumen in authorizing “valid” claims payments based on eligible expenses;
- Ability to “take” insurance risk via managing premiums and claims in a non-profit capacity as dictated by the ACA.

To analyze current capabilities within existing Illinois programs for administering these programs, information was collected from the Illinois Comprehensive Health Insurance (ICHIP) program. Wakely found no other existing Illinois state or quasi-state agency that has experience necessary for administration of these programs. ICHIP representatives responded to questions related to their current systems and how they might be leveraged for administering the federal temporary reinsurance program. Appendix D contains responses to those questions. Responses from ICHIP were obtained with the following clarifications, noting the uncertainty of the ICHIP program, possible legislative hurdles to overcome if it were to administer the program, and lack of expertise administering such a program:

> "1. At this point, CHIP's future after 1/1/14 has yet to be determined. If it were to continue to exist, it would probably be in a different form, with reduced staffing and funding. The CHIP Board will convene on 10/2/12 to deliberate its future under the ACA.
>
> 2. Although Section 4(h) of the CHIP Act (215 ILCS 105/4) authorizes CHIP to establish "rules, conditions and procedures for reinsuring risks," The Board has never exercised this authority. CHIP, as presently constituted, has neither reinsured risks nor acted as a reinsurer.
>
> 3. Section 1341 (d) of the ACA. reads as follows:
>
> (d) Coordination With State High-Risk Pools. -- The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.
>
> In order for CHIP to fulfill the reinsurance and risk adjustment functions specified in the ACA, the State would have to modify it by providing requisite funding and, probably, statutory direction. As presently constituted, CHIP lacks the funding and expertise to function as a reinsurer. Moreover, CHIP, in its present form, may not exist after 1/1/14."

While ICHIP has experience with program management and assessment collection, ICHIP has no experience with certain critical aspects of administering a reinsurance or risk adjustment program. Because the reinsurance program has more of a transactional focus, versus the risk adjustment program which has a deeply technical focus, administration of the reinsurance program would be more in line with ICHIP's current strengths than would the risk adjustment program. If Illinois considers administering these programs for the 2015 plan year, Wakely

recommends that the State conduct an open-bidding process, requesting that ICHIP provide a response alongside other non-profit entities. However, as noted above, ICHIP would not currently be an appropriate solution due to lack of expertise in this area. That being said, BCBSIL and Catalyst Rx currently provide administrative services for ICHIP claims adjudication and payment, so it is possible they could become partners with ICHIP in creating a solution that may be beneficial to the State with regard to administering the reinsurance program. Allowing ICHIP to bid a response may provide them an opportunity to present a new solution to administering the program.

A broader discussion of the administrative tasks required for a reinsurance program is described in Section 7.4, while overarching issues related to cash flow management are highlighted in Section 7.5.

7.2 Program Financing

State options and requirements for financing the administrative aspects of risk adjustment and reinsurance programs differ between the start-up/development period (prior to 2014) and the operational period (2014 and beyond). If Illinois considers administering risk adjustment during mid-2013 in preparation for the 2015 plan year, the State will incur costs to develop the infrastructure and functionality of the programs, as well as conducting initial analysis, simulations, and stakeholder outreach, but will not have an ongoing, dedicated revenue stream during this time.

In most cases, financing for these initial development and implementation expenses can be sought through Exchange Establishment grants from CMS. In cases where program elements will benefit the state's Medicaid program, costs will need to be allocated between programs and sought separately through a Medicaid Advanced Planning Document (APD), which are financed 90 percent through the Centers for Medicare and Medicaid Services (CMS). Once operational in 2014 or 2015, Illinois would need to develop an ongoing revenue source to support the administration, staffing, and ongoing maintenance of the programs.

Final regulations allow states to increase the reinsurance assessment to finance the administration of the reinsurance program, so no additional state or federal funding is required for the operation of the reinsurance pool. For risk adjustment, no such assessment is provided in the regulations, so states will need to develop a financing mechanism to support the program's operations. As they do for financing the Exchange, states have options with respect to a source of funding. One approach is to place the administration of the risk and reinsurance programs in the state Exchange and use establishment grant funding to design, develop, and build the required infrastructure. Ongoing cost can be included in the funding mechanism used to finance the Exchange (e.g., an assessment on participating QHPs or on the entire market). With the implementation of the ACA in general, Medicaid programs nationwide will have

changes. For Illinois, that could mean renewed interest in participation from Medicaid Managed Care plans. In such an environment, risk adjustment may be instrumental for appropriate payments based on risk attributes of the covered population. While different risk adjustment models would need to be utilized for a Medicaid population, there may be efficiencies and cost offsets that could be achieved by leveraging the newly developed Exchange function to calculate and administer the Medicaid Managed Care risk program. If Illinois pursues this option, you will need to develop the required inter-agency financing structure to support the added cost borne by existing staff and/or technology resources.

To determine the appropriate structure and financing source, as well as to assess the overall feasibility of supporting state administration of this function, Illinois must first assess the overall cost level required to run the risk adjustment program. Some key cost drivers for the ongoing maintenance and operations of the program will be the resources needed to staff and maintain the collection and storage of data; staff resources to perform ongoing reporting and analysis; staff resources to perform important plan management and communication functions; software licensing and updating costs; vendor costs in cases where key functions are outsourced; and actuarial and consulting fees for the development and analysis of program models and parameters.

The total cost of managing this program will vary considerably depending on several factors:

- Existing resources the state can rely upon, such as an existing APCD. The ability to leverage an existing data infrastructure will significantly reduce the cost to the state.
- Existing familiarity with risk adjustment models in other state programs such as Medicaid Managed Care.
- The level of state-specificity that states choose to pursue, including whether they wish to develop both their own model and administrative methodology, rely on the federal methodology but reweight based on a state-specific population, or rely on the federal model and only implement a state-specific payment adjustment methodology.
- The size of the insurance market and the number and variety of issuers and products sold in the state. Risk adjustment will be far more complex and time-consuming for states with more than 10 licensed issuers than for states with fewer issuers.

Based on a very high-level review of potential costs associated with administration of the programs, Wakely estimates that costs for Illinois to administer the risk adjustment program would be approximately one million dollars or less per year for the initial two years of the program. Thereafter, costs should decrease and stabilize to approximately $600,000 per year. These cost estimates assume that Illinois would have about the same number of commercial carriers participating in the individual and small group markets as it does today, and that the Illinois APCD would be fully functioning as a data source for the program. These cost estimates

do not include the cost of administering the APCD. An additional cost of approximately $200,000 per year is estimated beginning in year two of implementation to operate the required audit function for the risk adjustment program.

We estimate that administration of the reinsurance program would cost about half the expenses of a risk adjustment program. This includes limited staffing for the program and some external consulting and administration of the claims data associated with submitted recovery requests. We estimate that an additional cost of approximately $200,000 per year beginning in year two of implementation would be incurred operating the required audit function for the reinsurance program.

These estimates are based on costs we have seen proposed by consultants for similar work, with additional costs included for the staff of the entity administering the programs. As another data point, the Medicare Advantage program requires a $0.30 per member per month (PMPM) user fee for beneficiaries nationwide receiving medical benefits in 2013 (this is not a figure associated with the Part D user fee). We estimate that approximately 7.9 million Illinois health care members will be included in the assessment of the reinsurance program. If the $0.30 PMPM user fee were applied to the 7.9 million population projection, the total amount collected would be $2.4 million. The underlying allocation of the Medicare Advantage user fee is unclear, but we believe at least a portion of it goes toward funding the risk adjustment program. Portions of the user fee undoubtedly fund things not associated with Illinois administering the risk adjustment or reinsurance program under the ACA, so this should be viewed as a very high data point for comparability.

7.3 Establish Administrative Infrastructure – Risk Adjustment

Risk adjustment will generally require the state to access, store, and analyze large volumes of enrollment and claim data. As Illinois is contemplating using a distributed model for pre-implementation simulations, this may alleviate some of the more onerous data collection and storage requirements noted below. However, there will be some collection and storage issues to deal with, given the fact that data will still need to be collected by the State under the distributed model. This data will need to be reviewed and analyzed to validate that the results derived by carriers for their specific block of business were done in a manner consistent with the broader market and the prescribed methodologies. There has been some discussion of whether or not member-level risk scores will need to be collected under the distributed method.

Because risk adjustment will impact the entire individual and small group health insurance markets, collecting these data will be a substantial task for any state. States choosing to develop and administer this program will need to develop the capability to intake, cleanse, standardize, securely store, and analyze large volumes of issuer claims and enrollment data. Key elements of this activity will include the acquisition of data warehousing hardware and

software, with a dedicated staff to support the management, analysis, and reporting of this information, as well as the inevitable back-and-forth with issuers to ensure data accuracy and integrity. Other key requirements will include software licensing, maintenance, and updates, as well as developing the IT infrastructure and connectivity required to interface with issuers not only for the acquisition of claims and enrollment data, but also for information related to product rating and premium amounts.

Establish Data Warehouse and Reporting Capacity

States that do not have an existing APCD but want to administer the risk adjustment program will need to establish a data warehouse to store claims, as well as the system interfaces and management resources to accept, scrub, standardize, and maintain the integrity and quality of the data. Given the volume of enrollment and claims information states will need to house in this repository, the development, population, and management of such a database may be the single biggest and most costly task facing states contemplating the administration of their own risk adjustment program. States will need to carefully assess where they can leverage existing database platforms, where they will need to develop a new structure, what the cost of such an endeavor will be, and how it can be funded. Many states will incorporate the development of this warehouse in their Establishment Grant funding request, but the impact on state financing depends in part on how the proposed program governance is structured and whether or not the warehouse will integrate with existing state programs such as Medicaid.

In addition to robust data warehouse to support ongoing operations, the state will need to develop a data solution for preliminary planning and analysis, as well as the development of initial simulations. While these can be performed without the full functionality of a robust data warehouse, any interim solution contemplated will still require the accumulation of large volumes of claims and enrollment data and the capacity to analyze and report on this information.

Our recommendation is to out-source the data solution for the preliminary planning including modeling and pre-implementation simulations. If Illinois has a reliable APCD in operation for the 2015 plan year, then the State should certainly rely on that as the source for information, assuming the oversight of the APCD ensures validation of submitted data. If Illinois does not have an operational APCD in time for the 2015 plan year, administering risk adjustment will obviously be much more challenging. If Illinois chooses to proceed without an APCD for plan year 2015, we recommend establishing a data warehouse separate from other state entities, as that will enable Illinois to make critical time-sensitive decisions more quickly.

Establish Key Vendor Relationships

Many states that elect state risk adjustment will elect to outsource portions of the risk adjustment program, including the hosting and maintenance of the data warehouse, ongoing reporting and analytics, as well as the development and ongoing updates of risk adjustment parameters, models, and model weights. In addition, states will need to identify and procure

the necessary software packages to apply risk scores to individuals and issuers. Engaging this outside support will require time to be built in for RFP development and vendor selection.

Ongoing maintenance and operations

Once the state has gone live with the risk adjustment program, dedicated fulltime resources will be needed to ensure its successful implementation. Elements that the state will need to continue to monitor include: (a) data integrity concerns (enrollment and claims); (b) software updates to the risk adjustment tool; (c) creation of internal and external reports; and (d) issuer management. It is important to note that in addition to maintaining the database infrastructure and analysis, there will be important roles in communicating with issuers and engaging in ongoing interaction to address issues, field concerns, and communicate decisions and results.

7.4 Develop Administrative Infrastructure – Reinsurance

The oversight and administration of the reinsurance pool will require two types of functions. First, a policy-setting function related to setting parameters, issuing regulations, monitoring compliance, and reporting results to the market. Secondly, an administrative function focused on funds collection, management, and disbursement, as well as the development of policies and processes to ensure sound financial stewardship. Critical functions to manage this program include the establishment and periodic modification of reinsurance parameters; assessment collections and cash management; claim intake (summary level) and payment; analysis and reporting; and claims auditing.

Some of the key specific functions include the following:

- Specify source data for fully insured premiums to which the state alternative contribution rate would be applied.
- Define mechanism for issuers to submit these contributions to the state.
- Establish process and methodology to audit premiums on which the contributions were assessed.
- Collect contributions beyond the federal contribution rate, if Illinois chooses to require additional assessments.
- Define data required for submission of claims for reimbursement based on HHS guidelines, for non-grandfathered plans only.
- Remit the Treasury Department's portion of the reinsurance contributions back to the federal government.

- Complete detailed financial analyses and projections on the current and expected future federal contributions, attachment point, coinsurance rate, and reinsurance cap.
- Communicate methodology via a "state notice."

Identification or Establishment of Non-Profit Reinsurance Entity

The regulations require the establishment of a reinsurance entity, or the designation of an existing, non-profit reinsurance entity to carry out the provisions in the law. While the regulations suggest delegating this task to an independent non-profit entity, the regulations leave room for the possibility that this function can be overseen and managed by a state agency.

HHS has stated that it is permissible for a reinsurance entity to subcontract certain administrative functions as long as the state reviews and approves the contracts. The reinsurance entity will still remain the ultimate party responsible for all functions, but this will likely make it easier in the event that the state needs to set up a reinsurer.

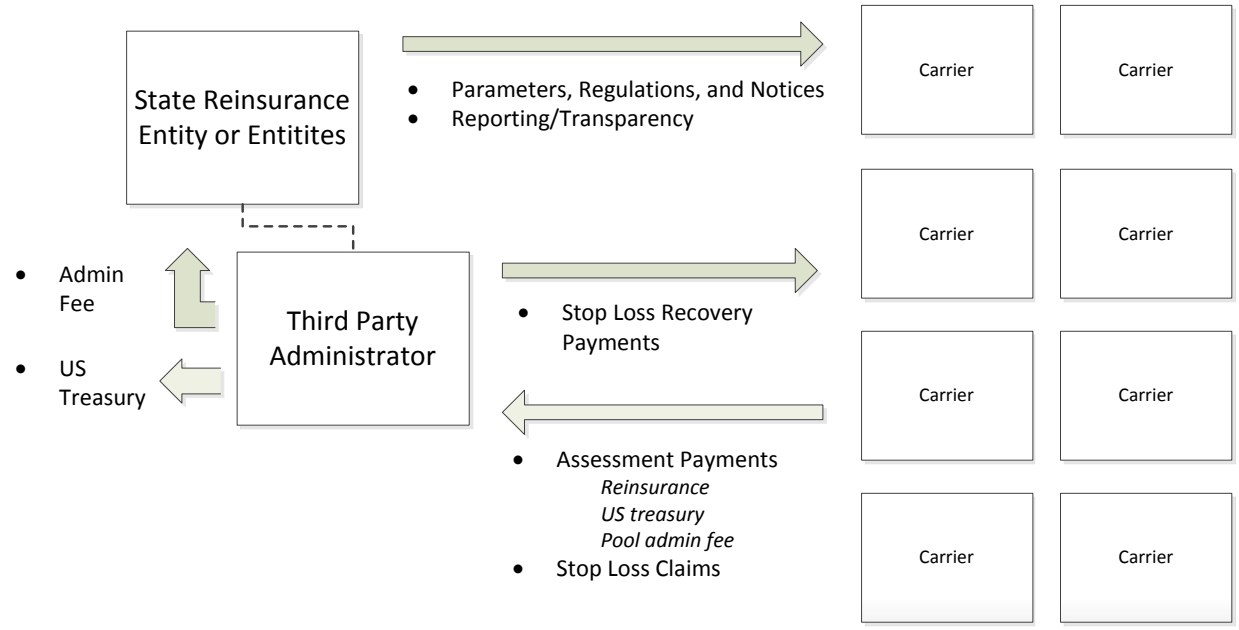
In addition, the regulation states that while a state can set up two administrators, this will likely lead to additional cost. They also indicate that this would only be permitted in the event that the reinsurance entities cover distinct geographic areas, which would require a state notice indicating this.

The requirement that a non-profit reinsurer be responsible for the reinsurance program will need to be specifically addressed through an existing entity or a newly established one. Illinois will need to review whether this type of entity exists in the State hierarchy or not.

Identify and Contract with Third Party Administrator

Some states will elect to administer the reinsurance pool utilizing existing internal staff resources, but most will probably elect the use of a third party administrator to run the operations of the pool, unless they have HHS perform this function. The state will therefore need to provide for the time required to issue an RFP and establish the operational interfaces needed to get the TPA integrated and up and running when making plans to establish the program.

Reinsurance Pool Administration



Claims Reimbursement Specifications

There are several major outstanding issues related to claims that have yet to be defined by HHS. The three most relevant issues are:

- the level of data required for reimbursement;
- definition of claims eligible for reimbursement; and
- reimbursement time frames.

HHS specifies that the reinsurance administrator will need to collect all data required to make payments, and that this will be provided in state notice and federal notice. Given the potential for reinsurance reimbursements at lower attachment points to be comprised of a large number of individual claims, providing data could be a non-trivial exercise especially if there is a requirement to meet certain electronic submission standards. On the other hand, as one of the program goals is "administrative simplicity," it would be logical to require the same amount of data as is required by commercial reinsurers.

Initially, in the proposed regulations, HHS defined that only "essential benefits" will be reimbursable under the program. NAIC strongly suggested that this is an unnecessary complication such that claims should be reimbursed on an "as paid" basis for simplicity. In the final rules, this change was made such that all services paid by a plan will be reimbursable.

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A final claims issue is the specification of a reasonable turnaround time for claims reimbursement, which is directly related to what happens if the reinsurance program runs out of money for reimbursements mid-year. Similarly, HHS asked for comments on a maximum time frame to report claims, after which they will not be eligible for reimbursement, in order to cap the liability for a claim at a certain time period. They suggested a six-month time period consistent with Medicare, but this still appears to be an open question for federal and state-run reinsurance programs. The solution for a state such as Illinois may be dependent on your particular method for dealing with overpayments in the program.

Effectively managing claims reimbursement to carriers to ensure that only legitimate claims are repaid is a very detailed and specific process – and very different than ICHIP's current role of having claims paid to a provider network through third-party administrators. Given that this is a key competency honed over the years by stop-loss carriers and large international reinsurers, this definition and tracking of claim submission requirements may be something better outsourced than built internally.

7.5 Establish Funds Flow Mechanisms and Cash Management Plan

Both the reinsurance and risk adjustment programs will require governing authorities to collect money from and make disbursements to issuers. In the case of reinsurance, the state will be collecting money from all issuers excluding self-insured plans, and making payments to issuers participating in the non-group market who submit valid claims for reimbursement from the pool. In the case of risk adjustment, the state will be collecting money from lower-risk plans and making payments to higher-risk plans. Supporting these cash management requirements has three key components: (1) financial management infrastructure and control; (2) timing of payments and collections; and (3) managing over and under collection of funds. As it relates more specifically to Illinois, the fiduciary responsibilities under these two programs may be more extensive than any current state agency can manage, especially in light of what will likely be fairly stringent federal requirements.

This is an important consideration for both programs, but it is particularly important to consider with regard to the timing of the reinsurance program. The risk adjustment program has no termination date, but the reinsurance program is only scheduled to reimburse claims incurred through 2016. The benefits of dedicating the time, effort, and cost of establishing such protocols will be experienced for many years with regard to the risk adjustment program. However, because of the short-term nature of the reinsurance program, if Illinois has not begun administering the program by the 2015 plan year, it does not seem like a worthwhile endeavor. If the State chooses to extend the life of the reinsurance program beyond 2016 by collecting additional assessments, a delayed start to administering the program may have more appeal.

Financial Management Infrastructure and Reporting

The entities governing both risk adjustment and reinsurance functions authority will need a basic financial management infrastructure, including dedicated bank accounts and/or specified

state funds, an accounting function to track funds and support public reporting, and the systems necessary to support making and accepting electronic payments. For reinsurance, the governing entity will be collecting funds from issuers on a regular basis and storing these funds to apply to future pool recoveries. Thus, the reinsurance authority should plan to provide periodic ongoing reporting to reflect total collections, recovery payments, and existing balance in the pool, as well as an annual report at settlement to reflect total collections and disbursements. For risk adjustment, most states will not be collecting money throughout the year in anticipation of future payouts, so ongoing reporting will be less intensive. However, the capability to accept, make, record, and report on electronic transactions will be necessary functions to support the program.

Timing of Payments and Collections

Under reinsurance, the state is required to ensure that payments to issuers cannot exceed collections, while risk adjustment is intended to be budget neutral, with collections balancing payments. While the proposed regulations do not establish specific timing requirements for the collection and disbursement of funds, establishing a schedule to ensure the state expends only monies that have been collected is an important aspect of program administration.

For risk adjustment, the proposed regulations contemplate a final settlement to occur six months following the end of a calendar year. Once calculations have been finalized, the state will need to collect money from plans determined to have lower risk members and, subsequent to collecting monies, making payments to plans determined to have higher risk members.

For reinsurance, the proposed regulations anticipate a more regular frequency of stop loss claim submissions and recovery payments, with final settlement to occur at a six-month lag from the end of the period. In this program, the state or its contracted vendor must develop a process to ensure that payments do not exceed collections during the year. A variety of options exist to achieve this, such as delaying payments for reinsurance claims until the last six months of the year when sufficient reserves have accumulated to sustain ongoing payments. There is also a widespread desire to collect funds sufficiently early to allow for claims reimbursement starting in February 2014. While HHS has proposed that contributions be collected monthly starting in January 2014, this may be difficult. Given the administrative burden of sending in monthly assessments, the NAIC has suggested that they be collected quarterly, in advance, based on anticipated premiums and claims. While this could work, it would also not be without challenges.

Managing Over and Under Collection of Funds

It is likely that in either risk adjustment or reinsurance, collections will be lower than payments[7]. States have a variety of options for managing the over or under collection of funds

[7] While risk adjustment is intended to be budget neutral, depending on whether the state elects to settle these payments on a regional basis or whether final normalization is used to effect budget neutrality, there may be

relative to claims, but the intended methodology for managing this issue should be clarified to the market prior to implementation to enhance certainty and transparency for issuers to set prices.

For risk adjustment, the possibility exists that charges collected will not be sufficient to cover payments, or vice versa. To achieve budget neutrality, the state will need to determine whether to reduce payments, increase charges, or both. In the event that charges exceed payments, the state will also need to decide whether to hold a reserve to stabilize future years, or adjust payments and/or charges to balance the pool to zero.

For reinsurance, the state is not permitted under federal regulations to disburse more in recoveries than it collects in assessments. It is contemplated, however, that they may collect more from issuers than is paid out in recoveries in 2014, 2015 and/or 2016. For the under-collection scenario, states will need to develop an approach, which could include, for example, (a) reducing recovery payments on a pro-rata or other basis to limit payments to the amount collected or (b) retrospectively increase assessment values to cover the full value of recoveries. In the over-collection scenario, states may be able to hold excess collections in reserve to off-set future shortfalls, or the regulations contemplate the possibility that states will adjust parameters in the following year to ensure any excess collections are paid out during that year.

It should also be noted that states are afforded the flexibility to adjust reinsurance parameters to manage the timing of collections and payments, which may be a cash management and stabilization tool. While the regulations set forth a targeted amount of funding to collect and disperse as part of reinsurance, states are able to alter the time frame within which these amounts may be collected. For example, a state could establish parameters in order to collect more money in year 1, thereby ensuring its ability to cover claims, and then adjust parameters in year 2 to spend down any reserve that accumulated.

7.6 Develop Reporting and Transparency Plan

Risk adjustment and reinsurance will both affect the premiums that issuers charge and how they adjust historic experience to develop pricing under reform. Therefore, it is important for issuers to receive information on the risk adjustment methodology and estimates of their risk scores for their current population under the proposed risk adjustment approach. This timeline should be exposed to the issuers for feedback to ensure it is consistent with their pricing cycle.

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instances in which collections and payments do not tie out precisely. See CCIIO Draft White Paper http://cciio.cms.gov/resources/files/riskadjustment_whitepaper_web.pdf and "Analysis of HHS Proposed Rules on Reinsurance, Risk Corridors and Risk Adjustment" http://www.rwjf.org/coverage/product.jsp?id=72682 for further details, including proposed options for distributing shortfalls/excess funds.

7.7 Establish Data Review and Audit Program

In many Medicaid programs, an informal process of reviewing and validating encounter data takes place between issuers and the state. This process typically involves member level risk scores and risk markers being provided by the state to the issuer, and some back and forth regarding data and results. In some instances, this process results in material corrections and improvements to the risk adjustment results. However, even if no issues are found or changes made, this process usually increases the comfort level in the methodology, data, and results.

CMS has begun Risk Adjustment Data Validation (RADV) Audits in the Medicare Advantage programs, which are audits of issuer-submitted diagnosis codes. Audits are completed on a relatively small sample of claims, and diagnoses that are not supported are excluded from a recalculation of the risk adjustment factors. The impacts on revenue, on a retrospective basis, can be significant – easily exceeding typical issuer profit margins. While only a small sample of claims is audited, findings from the samples are applied to the entire plan's revenue. The RADV audits have come under scrutiny because of the large amount of reconciliation dollars at stake. The reconciliations can be for services incurred a year or more in the past; by the time the audit occurs, plans have already established pricing and bids to CMS for the following plan year rather than having an opportunity to adjust their pricing. The more expeditiously and immediately audits can occur, the better they will be received by carrier.

The audit process proposed for risk adjustment under the ACA appears to be closer to RADV audits, with notable exceptions. However, many details are pending regarding available funding mechanisms, technical aspects, and allowable state flexibility. This work plan does not focus on this task given the uncertainty and because the timing is not as critical as other steps. However, the audits will require significant state resources for states that decide to operate the risk adjustment function and is therefore an important component of the overall decision-making process. In addition, discussing audits with stakeholders will be important.

Understanding shortcomings in the carrier claims data is one important reason to conduct simulations prior to implementation of the risk adjustment program. As Wakely conducts the simulations for the 2014 plan year on behalf of carriers, findings will help inform the carriers' processes which should ultimately help mitigate problems to be found in the audit process. One advantage of having Illinois administer the risk adjustment program is that the State may be able to implement specifics around audit issues more carefully and pointedly than HHS would otherwise. Ultimately, the purpose of audits is to improve the carriers' processes going forward while minimizing the burden of reporting information. The State may be in a better position to promote improvement than HHS, who may impose a one-size-fits-all approach to audits nationwide.

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8 Other Timeline Considerations: Coordination with MLR, Risk Corridor, and Other ACA Provisions

There has been considerable discussion regarding the interaction of reinsurance, risk adjustment, minimum loss ratio requirements, and risk corridors. While the interdependencies between these various programs are important from a modeling standpoint, they are less important from an operational standpoint.

In CCIIO's draft on "Risk Adjustment Implementation Issues," inter-dependencies were briefly mentioned. The main issue they identified was that certain issuers could potentially "double dip" by receiving reinsurance payments and risk adjustment payments for high-risk individuals. There was a brief discussion as to how a state might incorporate reinsurance payments in an alternative risk adjustment model, but no conclusive proposal as to the best manner to incorporate.

As it relates to the federally-administered risk corridor program, HHS has proposed that all cash flows from both the reinsurance and risk adjustment programs should be considered. This will reduce the ability of issuers to potentially "game" the system.

As it relates to the timing of cashflows for both reinsurance and risk adjustment, please see Section 7.5 above for a deeper discussion on how we see these inflows and outflows occurring.

Operationally, risk adjustment and reinsurance will need to be finalized before the Medical Loss Ratio (MLR) and federal risk corridor provisions can be applied. Therefore, the sooner risk adjustment and reinsurance activities are completed, the sooner MLR and risk corridor provisions can be applied. The timeline scenarios developed here are fairly aggressive regarding completing risk adjustment and reinsurance activities.

The most important issue may be the impact of risk adjustment and reinsurance audits. If HHS intends for MLR and risk corridor provisions to be applied after the effects of audits (or be applied before audit and then adjusted after audits) and the three year limit on audit completion is used, then final reconciliation for MLR and risk corridor programs may take several years to complete.

9 Risk Adjustment Implementation

Implementation of risk adjustment is complex, but feasible. The issues included in this report should assist Illinois in thinking through issues that apply in 2014 and beyond.

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9.1 Technical Implementation Issues

An important component of risk adjustment implementation is the exact way in which payments are calculated and the timing of their transfers. ACA legislates that payments are charged on plans with an actuarial risk that is below average, and that these payments are made to plans with risk that is above average. In terms of risk scores, a plan's actuarial risk is relative to the average risk score for the state/market/program baseline.

Payments will generally be calculated by multiplying a 'baseline premium' with the actuarial risk for a plan. The payments will be budget neutral at the state or program level. Two issues that need consideration are (a) what is the 'baseline premium,' and (b) how to make the charges and payments add up to zero (i.e. be budget neutral)?

A CCIIO whitepaper discusses various options in these and other related technical areas. (http://cciio.cms.gov/resources/files/riskadjustment_whitepaper_web.pdf)

9.2 The 3Rs Implementation Beginning in 2014

Prior to 2014, simulations and projections focus on providing plans with enough information so that they can price their 2014 plans properly. Beginning in 2014, simulations become reality, and the focus moves to implementation and cash flow. In this section, main objectives, important considerations to be addressed when choosing a methodology, action required of issuers and the Exchange, and the associated timeline around particular methodologies that could be employed are discussed.

It is important to realize the following objectives with respect to the reinsurance and risk adjustment programs:

1. The Exchange needs to provide issuers the type of information they will need to determine premiums and financial statement entries appropriately.
2. Data problems will exist and may significantly affect results, particularly with regard to risk adjustment. The state should work with the issuers to resolve data issues to the extent possible.
3. Provide results to issuers in a timely manner.
4. Minimize cash flow disruptions for the issuers. More frequent, updated payments for reinsurance recoveries and analysis of risk adjustment results will help support this objective.

Timing of the 3Rs for Plan Year 2014

Presented below and in Appendix E are expected timelines for the 3 R's programs for the 2014 calendar year. They are based on Wakely's current understanding of the most recent HHS guidelines and proposed timelines, although many have not been explicitly and firmly set as of today. The timelines for 2015 and 2016 are expected to be similar, but not necessarily identical, to those for 2014. Given the extremely compressed timeline for implementing the programs in 2014, changes in the following years may be either required and/or advisable due to improvements in methodology or additional time available in the schedule.

Our general viewpoint, which is based on opinions by the NAIC in their response to the NPRM, is that the deadlines by which reinsurance and risk adjustment activities must be completed should not adversely impact medical loss ratio (MLR) and risk corridor calculations. Therefore, timeframes should be no longer than when MLR and risk corridors need to be reported.

Reinsurance

Overview: Both assessments and reimbursements are expected to begin in the first quarter of the same calendar year during which the risks were underwritten (i.e. in first quarter 2014 for 2014 insurance risks).

- HHS would like this program to be implemented as early as possible in 2014 to provide cash flow to carriers experiencing anti-selection with the opening of the markets. HHS states in the Final Rule that, "applicable reinsurance entities could collect contribution funds intended for reinsurance payments and payments to the U.S. Treasury on a monthly basis beginning in January 2014 so that reinsurance payments could begin in February 2014".
- To ensure that this program is administratively simple, the NAIC has proposed the quarterly collection of assessments while still allowing for an early timeframe providing payments in the first quarter of 2014.
- As an example, the NAIC proposed that assessments could be requested in advance approximately two months prior to the beginning of each quarter (i.e. Oct. 31, 2013 for first quarter of 2014, Jan. 31, 2014 for second quarter, etc.). While this would require an estimate of premiums and assessments, it would allow the earliest possible program inflows in January of 2014.
- In reality, Wakely expects that very few reimbursements will be made in January, depending on the level of the reinsurance attachment points and the fact that claims details will need to be provided for any claims occurring in January. Also, many reinsurance programs require that the issuer actually pay the underlying claim before providing reimbursement.
- For simplicity, the NAIC would like the reinsurance timing to be set at a federal level to allow for simplicity in administration to issuers with premiums in multiple states. For the same reason, the NAIC has also opined that the "base" federal assessment rates should be consistent across states. While this consistency helps streamline the assessment collection process, there remains value in a state-based alternative

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mechanism that can alter timing of recovery payments, reinsurance parameters, and level of additional funding for the program that could help mitigate rate shock to the individual market beyond what the "base" federal assessment rates can allow.

- Of importance, states (or HHS) should seek to provide guidance to carriers by mid-year if there is an expectation that total assessments will be less than the projected reimbursements at the current reinsurance attachment points and coinsurance. This will allow insurers to prepare for any eventual reduction in the coinsurance percentage, for example. The NAIC also notes the possibility that there would be retroactive adjustments in 2014 due to the high level of uncertainty as to actual healthcare enrollment at the time that when parameters are set in 2013.
- Incurred but not reported (IBNR) reserves will be set up beginning in December 2014 or January 2015 until such time as the total claims for the reinsurance program have been substantially collected.

Risk Adjustment

Overview: While the timing of risk adjustment under the federal model has not yet been defined, Appendix E offers a likely overview of the risk adjustment timing related to the 2014 policy year. Interim simulations are assumed to begin in fourth quarter of the same calendar year during which the risks were underwritten (i.e. in fourth quarter 2014 for 2014 insurance risks). It is possible that the interim simulations occurring in fourth quarter 2014 are simply informative, giving the carriers more information regarding what to expect in terms of final payments and receivables, rather than resulting in the actual transfer of payments and reimbursements. Final payments are expected to occur in second quarter of the following year (i.e. in second quarter 2015 for 2014 insurance risks).

- HHS has stated the following, "We propose that all payment calculations must commence with the 2014 benefit year. The Affordable Care Act does not explicitly set forth a timeframe by which risk adjustment programs must start. However, we believe risk adjustment must be coordinated with reinsurance and risk corridors to help stabilize the individual and small group markets and ensure the viability of the Exchanges, which begin in 2014."
- In general, risk adjustment using medical diagnosis-based data requires six months of actual claims and three months of runout, which would indicate a fourth quarter payment at the earliest. Final settlement is expected to be six months after the end of the calendar year.
- Risk adjustment models based solely on pharmacy claims may be an option for state alternative approaches in the initial years of the ACA (2014 and perhaps 2015), but initial guidance suggests that the federal approach to risk adjustment will be diagnosis-based, which is also the case with the current Medicare Advantage risk adjustment model. A pharmacy-only based approach has advantages and disadvantages. One advantage is that simulations, payments, and reimbursements could occur earlier and more frequently than with diagnosis-based claims information since pharmacy claims

generally are reported, processed, and paid much more quickly than medical claims data. While use of a pharmacy only model would simplify simulations, it has the disadvantage of potentially creating a significant shift in the risk score by carrier once the full diagnosis-based model is implemented. This difference could be larger in the event that the percentage of children, who use less pharmacy, varies widely by carrier.

- The NAIC's response to the NPRM was that risk adjustment should require submission of data within two months of the end of the year and completion of calculations and billing before the end of the 2nd Quarter. This was based on a review of a risk adjustment program in place in New York State.
- Utilizing this New York State timeframe for our interim, mid-year adjustment would require a calculation by the end of August and payments by December of 2014. Given the additional complexity of implementing a new program in 2014 and the possibility that data may need to be forwarded to HHS, we have pushed this proposal by one month on our accompanying timeline. This may also allow the collection of an additional month's worth of data.
- States and/or HHS will want to ensure that risk adjustment payments be collected from carriers with better than average risk prior to being required to make payments back to those carriers with greater than average risk, which has been reflected on the timeline.
- Results would be audited during the remaining six months of 2015.
- Deciding on risk adjustment methods to be used in early 2014 for carriers pricing 2015 products will involve careful consideration for each state. Even if HHS administers a state's risk adjustment program, it is highly doubtful that data will be collected, summarized, and distributed by HHS and provided to carriers within the first half of 2014 in time to affect pricing for 2015 products. Three main options for states wanting to assist carriers in establishing 2015 rates are described as follows:
    - Distributed Approach Using 2013 Information for Proxy:
        - Collect diagnosis-based prevalence reports from carriers based on 2013 claims as well as only first quarter 2013 experience separately. Obtaining prevalence reports for first quarter 2014 would be ideal; however, timing may not allow for that analysis unless 2015 rate filing submittals can be pushed into late third quarter 2014.
        - Compile the prevalence information by disease state for the individual and small group markets separately. Provide these overall market summaries to all participating carriers.
        - Using these overall market statistics and average risk scores, carriers would be able to run their data through the risk adjustment model for different time periods (first quarter 2013, full year 2013, and first quarter 2014) and compare it to the state-provided overall market information.
        - For individual carriers, a separate adjustment will need to be made to account for the previously uninsured members who are enrolled in their plans in 2014. To do so, it will be imperative for carriers to be able to identify members who were previously uninsured, whether it be

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information gathered by the state at the point of enrollment into the Exchange, or information collected directly by the carriers.
        - Also, adjustments may need to be made for the individual market analysis if the pre-2014 covered benefit packages in the market differ significantly from the post-2014 environment such that impactful diagnoses would not have been captured in the pre-2014 prevalence reports.
    - State Centralized Approach with Prospective Application:
        - For the small group market, it would be possible for states to gather calendar year 2013 claims data in January 2014 (with no paid claim run-out) and calculate member-specific risk scores. Obtaining 2014 member-specific enrollment information would be important so that a carrier's risk score in 2014 would consist of the risk scores of the actual members enrolled in its plans during 2014. Obtaining, analyzing, and summarizing the data for the entire small group market may be an overly burdensome process for Illinois, though. This approach makes the most sense if the actual risk adjustment transfers in 2014 use an approach that incorporates 2013 claims data (this would be consistent with the Medicare Advantage risk adjustment methodology timing structure).
        - Because the individual market expects such a large influx of new previously uninsured members in 2014, and due to typically reduced benefit packages prior to the incorporation of essential health benefit regulations in 2014 (e.g., maternity and mental health), the centralized approach for the purpose of providing information to assist with setting 2015 prices does not seem feasible for the individual market.
    - Demographic only: At a minimum, enrollment information for the individual and small group markets should be compiled in order to determine overall market demographics. This information can be compared to a carrier's enrolled demographics in order to determine the relative demographic risk after normalizing for the 3 to 1 age ratios allowed by the ACA. Because this comparison is only focused on their amount of risk beyond 3 to 1 in comparison to the overall market's, the usefulness of this type of modeling is minimized.

Risk Corridor

Overview: Risk corridor payments can likely not occur until the third quarter of the calendar year following the year during which the risks were underwritten (i.e. the third quarter 2015 for 2014 insurance risks).

- As it relates to the federally-administered risk corridor program, HHS has proposed that all cash flows from both the reinsurance and risk adjustment programs should be

considered. This will reduce the ability of issuers to potentially "game" the system, but pushes out the timeframe significantly.

- In order to account for all other cashflows, we have assumed that risk corridor payments will not occur until the third quarter of 2015.
- The timelines noted above are fairly aggressive regarding completing risk adjustment and reinsurance activities.

Minimum Loss Ratio (MLR)

Based on proposed MLR regulations, the denominator of that figure has been defined as, ''premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance." Therefore, risk adjustment, reinsurance, and risk corridor cashflows will need to be finalized before the (MLR) provisions can be applied. So, the sooner risk adjustment and reinsurance activities are completed, the sooner MLR and risk corridor provisions can be applied. This leads to the conclusion that the timelines and reporting requirement deadlines noted above need to be standardized to allow for well-communicated and uniformly recognized timeframes to complete various MLR reporting.

Currently, HHS has indicated that the MLR and risk corridor provisions will be applied after the effects of audits - or be applied before audit and then adjusted after audits. Therefore, if the three year limit on audit completion is used, then final reconciliation for MLR and risk corridor programs may take several years to complete. This will need to be further developed as additional guidance from HHS is communicated.

The PHS Act section 2718(a) requires reporting of ''premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance.'' Because this language so closely parallels the three programs added by the Affordable Care Act (the transitional reinsurance program established by section 1341; the risk-corridor program established by section 1342; and risk adjustment under section 1343 of the Affordable Care Act), we interpret this requirement as applying exclusively to payments under those provisions, which are not effective until 2014.

Interim (Initial) MLR Reporting

The final rules require risk adjustment and reinsurance activities to be completed by June 30th of the year following the plan year (i.e. June 30th 2015 for 2014). This actually conflicts with proposed MLR reporting requirements, which have a June 1 filing date. However, HHS indicated in the final rules that they are working on a solution. In order to complete what we will call the "initial reporting" by the proposed date of June 1, carriers may need to calculate estimates prior to preliminary results being available. We have assessed the ability to meet these deadlines for MLR reporting by program below.

- Reinsurance: With a reasonable claims reporting timeframe of six months, reinsurance results should be estimated by June of 2015 for 2014. As MLR rules allow carriers to establish unpaid claim reserves and consider the same for payment, this should effectively bridge the time between interim and final assessment. In reality, IBNR will be assessed throughout the life of the program and updated as the 2014 claims year becomes more complete through the receipt of claims. Therefore, providing an estimate as of April 30, 2015 for use in a June 1 filing is feasible.
- Risk Adjustment: Based on our timeline allowing for a three month runout period, results for risk adjustment wouldn't be available until May or June for the full year 2014 claims incurred. Depending on the final timing of reporting requirements (which are due June 30th for their reference New York State program), the NAIC believes that an earlier billing notice would be helpful in establishing an initial MLR report. Our current timeline contains preliminary estimates based on the simulations conducted in fourth quarter 2014, but the state may want to consider another updated simulation in early 2015 for this purpose.
- Risk Corridor: In our proposed timeline, an initial review of risk corridor results would only occur in the third quarter of 2015 for the 2014 year. In order to complete an MLR report filing on June 1, carriers would need to simultaneously estimate risk corridor and MLR results in May based on preliminary reinsurance and risk adjustment results.

Final MLR Reporting

The interim MLR reporting contemplated for June 1, 2015 (referencing year 2014) will be completed prior to a full reconciliation of risk adjustment and reinsurance audits, which will finalize results for these programs. While it is expected that these audits could result in significant changes for calendar year 2014, future years should exhibit much less volatility given the lower expected change in the profile of the insured population and carriers' increased familiarity with the programs.

Scenarios for 2014 and 2015

There are different options regarding risk adjustment administration that could be employed by a state in 2014 and 2015 after careful consideration of the items discussed above, and based on approval by HHS. The following is a list of three possible options for implementation. Other options exist as well; these three options are intended to provide ideas around the general concepts of timing and process.

Option A: Interim Method Beginning Later

This option is displayed in our post-2014 detailed timeline in Appendix F and assumes that HHS will administer risk adjustment for the 2014 plan year, and the State will administer risk adjustment for the 2015 plan year. This option involves the following components:

1. Medical claims data for the first six months of 2014 with three additional months of claims payments would be collected in October 2014.

2. The State would analyze the information submitted, calculate the interim risk scores, and distribute results to the carriers. If HHS administers the risk adjustment program in 2014, Illinois could still receive data from the plans (perhaps in the form of the APCD), analyze the information submitted, and distribute results to the carriers, without actually collecting and distributing payments to carriers. This would still be helpful to carriers for planning purposes and financial reporting. We do not believe that HHS will provide any interim information to carriers.

3. Prior to the final risk score determination by HHS for the 2014 plan year, the State would collect monthly enrollment data from carriers in order to update risk score estimates.

4. In March and April 2015, medical claims (perhaps alongside pharmacy claims) would be obtained for dates of service in 2014. A concurrent, medical claims-based risk adjustment model will be applied to the 2014 claims. Final collections and payments associated with 2014 experience, as determined by HHS, would be transferred in May and June 2015.

5. Using 2014 claim data available in April 2015, a prospective approach would be applied for interim risk score calculations for the 2015 plan year.

6. For plan year 2015, monthly calculations and payment distributions between the interim analysis and the final reconciliation would be performed by using the member-specific risk scores determined in the interim analysis and subsequent enrollment data showing movement of members. Risk adjustment payments for issuers would be re-calculated on a monthly basis.

7. Final reconciliation for the 2015 plan year will be based on 2015 medical (and perhaps pharmacy) claims data and a risk adjustment model with concurrent weights.

The timeline in the following table assumes that HHS administers the risk adjustment program for the 2014 plan year, and that Illinois will administer the program for the 2015 plan year. As stated previously, under this scenario, there will be no interim collections and payments for the 2014 plan year, however, the State can still perform important functions throughout 2014 as shown in the following table that would help inform carriers before HHS performs the final collection and distribution in 2015.

Table 7: Option A for 2014 and 2015 Policy Years

Option A: Interim Risk Model Beginning Late 2014

	Implementation Step	Timing
1	Health plans submit 1st half of 2014 data, with 3 months of run-out, to State	Oct 2014
2	State calculates and reports risk scores	End of November 2014
3	Health plans submit full year 2014 data to HHS	Mar - Apr 2015
4	HHS bills and collects final 2014 risk adjustment payments, then makes payments to carriers	May - Jun 2015
5	Health plans submit 1st half of 2015 data, with 3 months of run-out, to State	Oct 2015
6	State calculates and reports interim payments (in and out)	End of November 2015
7	State collects interim payments from low-risk carriers	Dec 2015
8	State distributes interim payments to high-risk carriers	Jan 2016
9	Health plans submit full year 2015 data to State	Mar - Apr 2016
10	State bills and collects final 2015 risk adjustment payments, then makes payments to carriers	May - Jun 2016

While not shown on this timeline, a state can choose to perform monthly calculations (amounts paid and received) once initial risk scores are assigned to members, as shown in Appendix F. This process would allow payments to be made more frequently between January and June following the plan year being analyzed. Monthly calculations would be based on shifts in enrollment rather than incorporation of new diagnosis data. As with any risk adjustment method, members without a sufficient amount of enrollment would obtain a default risk score (perhaps a demographic score or the plan's average risk score for other members).

HHS does not plan to incorporate any interim modeling or payments. Please refer to Option C for a discussion of that approach.

Option B: Interim Method with Earlier Results for the Previously Uninsured

Similar to Option A, this option also incorporates interim risk adjustment analyses during 2014 and final reconciliation in by June 2015. The unique feature of Option B is that for purposes of the interim analyses during 2014, risk scores for the people who were insured prior to 2014 would be based on medical data in 2013. The risk scores for people who were previously uninsured and are new to the market in 2014 would be based on a pharmacy-only model. Toward the end of 2014, the interim risk scores for all 2014 members could begin to be based on medical data. This option would allow interim dissemination of risk score information during 2014 to begin earlier within the year than other options, particularly for the newly insured population. Using a pharmacy-only based model is not anticipated to have a bias of either over- or under-estimating the actual risk of the incoming uninsured population. However, the methodology used for the interim payments would differ from the model used for the final payment and therefore, significant adjustments to final results produced in 2015 could occur. The degree of significance is dependent on many items such as the size of the incoming uninsured market, the distribution of the incoming uninsured market amongst the various carriers, the actual medical-based model used, and the actual pharmacy-based model used.

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Although unlikely, there could be scenarios in which estimates of net payments prior to reconciliation become net recoveries, or vice versa, for a particular entity. Also, HHS has concerns[8] about the use of pharmacy data for risk adjustment purposes, so pending further guidance, it is not clear if incorporation of pharmacy claims data will be an allowed approach under a state alternative approach.

The timeline in the following table assumes that HHS administers the risk adjustment program for the 2014 plan year, and that Illinois will administer the program for the 2015 plan year. Option B differs from Option A in the timing and type of data collected in 2014.

Table 8: Option B for 2014 and 2015 Policy Years

Option B: Interim Risk Model Beginning Earlier in 2014, with More Immediate Information for Previously Uninsureds

	Implementation Step	Timing
1	Health plans submit 2013 medical data and 1st quarter of 2014 Rx data, to State	May 2014
2	State calculates and reports risk scores	Jun 2014 - Aug 2014
3	Health plans submit 2nd quarter of 2014 Rx data to State	Aug 2014
4	State calculates and reports risk scores	Sep 2014 - Nov 2014
5	Health plans submit 2014 medical data to-date to State	Nov 2014
6	State calculates and reports risk scores	Dec 2014 - Feb 2015
7	Health plans submit full year 2014 medical data to HHS	Mar - Apr 2015
8	HHS bills and collects final 2014 risk adjustment payments, then makes payments to carriers	May - Jun 2015
9	Health plans submit 1st half of 2015 data, with 3 months of run-out, to State	Oct 2015
10	State calculates and reports interim payments (in and out)	End of November 2015
11	State collects interim payments from low-risk carriers	Dec 2015
12	State distributes interim payments to high-risk carriers	Jan 2016
13	Health plans submit full year 2015 data to State	Mar - Apr 2016
14	State bills and collects final 2015 risk adjustment payments, then makes payments to carriers	May - Jun 2016

Option C: No Interim Model

This option would be the easiest to incorporate because it is simply the final step of Options A and B, meaning there would be no interim payments distributed throughout 2014. Payments would not be distributed until the May to June 2015 time frame. The main disadvantage of this option is the delay in the transfer of payments. This delay would result in large payable and receivable amounts that issuers will be obligated to keep on their books throughout 2014, and as of December 31, 2014 in particular; not only will the magnitude of these figures be very large

[8] HHS provides the following examples: 1) "Including prescription data in a risk adjustment model, however, could offer powerful incentives to steer treatment toward pharmaceutical therapy in order to identify risk of the enrolled population" even when it may not be clinically preferable, and 2) "clinical indications for a given pharmaceutical may change over time, prompting the need for more frequent modifications to the risk adjustment model than if pharmaceutical data were not used."

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for some issuers, there will be an extremely high degree of uncertainty in the associated underlying assumptions.

Option C is consistent with what we understand the federally-run program to be.

2015 and Beyond

There are different approaches that can be taken in 2015 and beyond regarding implementation of risk adjustment but, in general, the more the markets stabilize in terms of people covered, the methodology incorporated can also stabilize. It is anticipated that there will continue to be an influx of currently uninsured people into the market in 2015 as the penalty for remaining uninsured will increase, but not as much of an influx as will be seen in 2014. In 2016, it is anticipated an additional influx of new members into the market as the penalty is increased again; however, in years after that, it is expected the markets will experience a minimal influx of new members due to the individual mandate.

Particularly while a significant number of people are entering the market, continuing to have final risk adjustment payment distributions based on a concurrent model using that particular year's diagnoses is recommended, whether that be in conjunction with options A, B, or C mentioned previously.

9.3 Conclusion

The Affordable Care Act provisions fundamentally change the rules of the health insurance marketplace. The risk adjustment and reinsurance provisions of the ACA are critical risk mitigation tools, necessary to create an efficient and robust market. CCIIO, states, health plans, consumers, providers and other stakeholders need to work together to make reform successful. A substantial amount of this collaborative effort needs to take place on these specific programs and on healthcare reform more generally before 2014 as outlined in this paper. For a listing of the key steps necessary to implement either or both of these programs, please refer to Table 1 in the executive summary and the attached appendices.

Wakely makes the following recommendations, with considerations specific to Illinois' existing programs and capabilities, and the timing associated with program implementation.

- We recommend that Illinois not administer the risk adjustment or reinsurance programs for the 2014 plan year.
- If Illinois will not have an APCD that collects reliable 2014 plan year data for all fully insured small group and individual market members, we do not recommend administering risk adjustment for plan year 2015.

- If Illinois will have an APCD in place in 2014, State administration of risk adjustment for plan year 2015 would be feasible. There are advantages to having Illinois administer the risk adjustment program, but it would be a complicated endeavor for Illinois, with an untested APCD, several carriers involved, and a lack of experience with risk adjustment programs in general. Carrier input is important to this decision, and interviewing carriers was outside our scope of work for this report. However, based on our knowledge of Illinois-specific considerations, we do not currently recommend that Illinois administer risk adjustment for the 2015 plan year.
- We recommend that Illinois consider administering reinsurance for the 2015 plan year. While it is easiest for the State to allow HHS to administer the reinsurance program, having Illinois administer alternative assessments and parameters for reinsurance recoveries may lower the rate shock for the individual market in 2015, 2016, and beyond, perhaps making it a worthwhile proposition for Illinois.
- We recommend that Illinois perform risk adjustment and reinsurance simulations in early 2014 to assist plans in pricing their 2015 products.

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